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INDIAN HEALTH FACILITIES

HEARING

BEFORE THE

SELECT COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

ON

OVERSIGHT HEARING ON INDIAN HEALTH FACILITIES

MARCH 22, 1990
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CONTENTS

Statements:

Page

- Archambault, Donovan, chairman, Fort Belknap Community Council, Harlem, MT 33
- Biswell, Vic, Association of California Hospital Districts 28
- Black Thunder, Everett, tribal manager and planner, Sisseton-Wahpeton Sioux Tribe 38
- Bouschor, Bernard, tribal chairman, Sault Ste. Marie Tribe of Chippewa Indians 15
- Cournoyer, Steven, Jr., chairman, Yankton Sioux Tribe, Marty, SD 39
- Ellis, Myron, member, Leech Lake Reservation Tribal Council 34
- Hawkins, Russell, chairman, Sisseton-Wahpeton Sioux Tribal Council, Sisseton, SD 35
- Hostler, Jasper, Jr., vice chairman, Hoopa Valley Business Council, Hoopa, CA 26
- Human, Jeff, Director, Office of Rural Health, Department of Health and Human Services, Washington, DC 5
- Koortbojian, George, St. Joseph Health System 27
- Loonsfoot, Charles, tribal council member 23
- McCain, Hon. John, U.S. Senator from Arizona, vice chairman, Select Committee on Indian Affairs 1
- Paiva, James, tribal chairman, Shoshone-Paiute Business Council 17
- Pinkham, Allen, chairman, Nez Perce Executive Committee, Lapwai, ID 28
- Racette, Pat, director, New Day Treatment Center, Keweenaw Bay Indian Community, Baraga, MI 23
- Rhoades, Dr. Everett, Director, Indian Health Service 4
- White, Lorraine, president, Quechan Tribal Council, Yuma, AZ 13

APPENDIX

Prepared statements:

- Archambault, Donovan (with Feasibility Study) 117
- Bouschor, Bernard 66
- Colorado River Indian Tribes (with attachments) 330
- Confederated Tribes of the Warm Springs Reservation of Oregon (with briefing paper) 203
- Ellis, Myron (with attachments) 156
- First Nations Financial Project on behalf of the Brotherhood Community Health Clinic, Pine Ridge Indian Reservation (with attachments) 355
- Hawk, Johnny T., president and chief executive officer, Calista Corporation 115
- Hawkins, Russell (with attachments) 169
- Hostler, Jasper, Jr. (with attachments) 94
- Human, Jeff 53
- Koortbojian, George 101
- Loonsfoot, Charles (with attachments) 74
- Murkowski, Hon. Frank H., U.S. Senator from Alaska (with letter) 112
- Native American Women's Health Education Resource Center (with attachments) 245
- Paiva, James (with letter) 69
- Pesata, Levi, president, Jicarilla Apache Tribe, Dulce, NM 616
- Pinkham, Allen (with attachments) 105

Page

Racette, Pat (with attachments) 74
Rhoades, Dr. Everett 45
White, Lorraine 62

Other material submitted for the record:

Baker, Frederick, Health Systems Administrator, letter to Allen Pinkham 579
Batliner, Terrence, phase I scores, health facility construction priority system, memorandum and letter 561, 584
Bell, Wesley M., memorandum 587
Comprehensive Environmental Health Survey Report, Lapwai Health Center, John Sery, Deputy Environmental Health Specialist 543
Current Health Status of the Wagner Service Unit Area and the Effects of Indian Health Services Proposed Inpatient Service Closure 275
Hobbs, Straus, Dean & Wilder, letters reprensenting the Metlakatla Indian Community, Northern Sound Health Corporation, and Bristol Bay Health Corporation health facility needs (with attachments) 388, 590
Kauffmann, Jo Ann, Evergreen Associates, letter from Dr. Rhoades 585
Native Health Service Hospital Abestoes Survey Report, Dillingham, AK (with attachments) 596
Norton Sound Health Corporation Hospital, Nome, AK, Project Manuel Schematic Design, Livingston Sloane Inc. 396
Pearson, Bill, temporary construction projects, memorandum 573
Pinkham, Allen, letter to Terrence Batliner 582
Summary of attachments regarding IHS facility replacement at Lapwai, ID 529

INDIAN HEALTH FACILITIES

THURSDAY, MARCH 22, 1990

U.S. SENATE,
SELECT COMMITTEE ON INDIAN AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 9:30 a.m. in room 485, Russell Senate Office Building, Hon. John McCain (vice chairman of the committee) presiding.

Present: Senator McCain.

STATEMENT OF HON. JOHN McCAIN, U.S. SENATOR FROM ARIZONA, VICE CHAIRMAN, SELECT COMMITTEE ON INDIAN AFFAIRS

Senator McCAIN. The committee will come to order.

I appreciate the time that each of you are taking from your busy schedules and the considerable distance some of you have traveled to join us for today's hearing.

This hearing has literally been 1 year in the making. Today's hearing will focus on two issues related to health care facilities and programs, primarily those in rural areas of Indian country.

First, is whether there ought to be more flexibility in the type of health care facilities that are constructed and programs that are implemented in Indian country.

Second, is whether we ought to permit the use of non-IHS dollars for the purpose of constructing Indian health care facilities.

I know most of the people in this room share my deep concern for the fact that our Nation's first citizens have the lowest health status of any population group in America.

I am committed to see that their health status continues to be improved. Certainly, the Indian Health Service [IHS], under the able guidance of individuals such as Dr. Rhoades and his predecessor, Dr. Johnson, has had much success in dealing with the threat that many common diseases and maladies pose to the lives of Native Americans.

I am sure that with the limited resources available, it is a constant battle to make further inroads into improving the health status of Native Americans, but there is always more that can be done, and with regard to resources, we on the committee hope to do something about the declining level of resources.

As we all know, health care generally is in a process of rapid change. Many services which used to be delivered only in an inpatient hospital are now being delivered in an outpatient setting, within the doctor's office, and even at home.

Correspondingly, there is great change in the types of facilities that are being built and health programs that are being implemented to address the changes in health care delivery, as well as the ever-increasing financial constraints due to the rapidly escalating cost of our Nation's health care delivery system.

In most areas of the health care delivery system it is a question of how those resources might best be utilized. Jeff Human, Director of the Office of Rural Health within the Department of Health and Human Services, has been gracious enough to take time from his busy schedule to join us this morning to talk about some innovative things that are being done in rural America's health care delivery system.

I think we will find that much of what is being learned and demonstrated is indeed applicable to Indian health care as well.

Reality dictates that the days of a full-blown, large inpatient hospital in every community, yes, even Indian communities, are probably behind us, but this does not in turn mean that a community should be forced to forego access to health care services, including inpatient beds.

This is true for rural America, and it is true for Indian country. This morning we will hear many of the innovative ideas ranging from outpatient clinics with overnight stay beds to treat conditions such as foot complications from diabetes to hydration to wellness centers.

Some even wish to be given the opportunity to join forces with the non-Indian community and develop a facility that serves both Indians and non-Indians or to be able to tap non-IHS funds for the construction of IHS facilities.

While I do not believe any of this should be coerced, at the same time we should not stifle this innovation and that is exactly what our current policies are doing.

Over the past couple of years, I have been watching with interest and concern as recommendations have come forward to close or dramatically alter existing Indian health care facilities in favor of consolidating services or replacing an existing facility with one offering a scaled down level of services.

Many in the Native American community feel that such action may lead to a further deterioration in access to care, and the end result being a decline in health status rather than an improvement.

I have to say that in many of these cases, I agree. On further exploration of this issue, I found a wealth of ideas among those in the Native American community with regard to how resources might be used differently so that rather than decreasing access to health care it would be enhanced.

When I took this issue to Dr. Rhoades about 1 year ago for the purpose of exploring how we might be able to work together to make the system more flexible, I was heartened to find that he has been thinking that this change was needed as well.

Dr. Rhoades, it has been a great pleasure being able to explore this issue together as we have, and I look forward to continuing our work on this issue.

I know that I speak for the affected tribes when I express to you my appreciation for your having put on hold any proposed closures of inpatient beds until we had a chance to thoroughly work through the process we have been undertaking.

Today, we will hear from several witnesses representing tribes or facilities on the list I just spoke of, as well as witnesses representing tribes which have some very innovative ideas for what they could do if the current system were more flexible.

I do not believe the fact that tribes have innovative ideas is anything new. As many of you know, we found the same innovation present with regard to mental health, which led this committee and the Senate to adopt legislation to fund a demonstration project that will give tribes the key for change in that area.

This type of empowerment, giving the keys of change to the very population to be served, is very consistent with the whole concept of self-determination.

I think the amount of interest in this hearing is reflective of the desire of a good number of tribes in being able to explore different approaches in to meet health care needs.

In fact, we have already three times as many tribes interested in testifying as we have slots to accommodate witnesses.

As such, I will be asking and submitting for the record some questions regarding a few tribes that were not able to participate in today's hearing, specifically, the Colorado River Indian Tribes and the Oglala Sioux Tribe.

I have come to the conclusion that it might be a good idea to set up on a small scale a pilot program that would provide some flexibility to allow tribes to demonstrate some of their ideas about how their health care needs might be met more effectively and/or appropriately.

The concept I have in mind at this point, however, is along the lines of establishing a program that would empower Native Americans with the opportunity to demonstrate, by providing some flexibility in the current system, whether Indian health programs can be structured more effectively.

Obviously, one of the major issues that has to be resolved is the question of how to make sure that when commitments are made to construct the facilities, funds for staffing will be appropriated and allocated.

At the outset, I hope that everyone understands that my desire to see a demonstration priority system put in place would not in any way threaten the status of those tribes who are in the existing priority system.

Nor should any movement in the direction of permitting the construction of facilities with moneys that are wholly or partially non-IHS be construed to mean that we are going to eliminate or decrease the level of Federal commitment to facilities construction.

In point of fact, I believe if there is to be any change in Federal appropriations for health facilities construction, it surely ought to be an increase.

We have more need than we can currently meet; therein lies the fundamental point. Not only might such a demonstration project make services available in areas where they're not currently available, it would permit us to learn what changes ought to be made in the way in which the IHS currently approaches health programs and facilities construction.

I believe that whatever comes from the hearings of any demonstration project that is ultimately put into place will hold much promise because we are putting the keys for change into the hands of those who ought to have them, the very people who are affected either positively or negatively by whatever health care service delivery system exists.

Again, it is my hope that the chairman of the Select Committee on Indian Affairs, my good friend, Senator Inouye, will agree with me that this is an issue which ought to receive high priority for action this year.

I look forward to working with him and other members of this committee, the Senate, the Administration, and, most of all, our Nation's first citizens in addressing the issue of how we might best be able to continue to improve our efforts in meeting the unmet health care needs of Native Americans.

Senator Daschle has asked me to express his regrets at being unable to attend the hearing this morning. He will be chairing a hearing being conducted by his Agriculture Subcommittee in Agricultural Research.

He also asked that I especially welcome not only Russell Hawkins and Everett Black Thunder, from Sisseton-Wahpeton, and the Chairman of the Yankton Sioux, Steve Cournoyer.

Steve, while not testifying, will be submitting important testimony to the committee on behalf of the Wagner Indian Health Service Unit.

I apologize for the length of my opening statement. This is a very innovative proposal that we are examining here this morning, and, of course, with any innovation, there is always controversy and misunderstanding.

So therefore I felt it was necessary to give a rather substantive opening statement. With that, I would like to welcome our first panel members, Dr. Everett Rhoades and Mr. Jeff Human.

Dr. Rhoades, as we all know, is the Director of IHS in Rockville, MD. Mr. Jeff Human is Director, Office of Rural Health, Department of Health and Human Services, Washington, DC.

I would also like to welcome my friend from Arizona, Javier Mercado, who is with us this morning. Welcome, Javier.

Will you proceed, Dr. Rhoades, and we will catch Mr. Human when he arrives. Thank you for joining us this morning.

STATEMENT OF EVERETT R. RHOADES, M.D., DIRECTOR, INDIAN HEALTH SERVICE, ACCOMPANIED BY JOHN PORVAZNIK, ASSOCIATE DIRECTOR; AND BILL PEARSON, ASSOCIATE DIRECTOR

Dr. Rhoades. Thank you very much, Mr. Chairman.

My name is Everett Rhoades. I am the Director of the IHS, and I am joined, on my left, by Dr. John Porvaznik, the Associate Director for Health Programs, and on my right, Mr. Bill Pearson, the Associate Director of our Office of Environmental Health and Engineering.

Assuming that my opening statement would be included in the record, Mr. Chairman, and with having left, I think, very little additional that needs to be said about this topic from your own comprehensive opening remarks, let me just make a couple of observations that I would like to be sure are on the record.

First of all, the IHS, I think, clearly has demonstrated over the years, particularly, as you pointed out, in Dr. Emery Johnson and his predecessor's tenures, some of the innovative ideas to be introduced into medical care, whether that is community health representatives or community health aides in Alaska, sanitation programs, and so forth.

So for that reason, I find it exciting the examine the question that you placed before us as well. The preoccupations that the IHS has in relationship to the goal of raising the status of Indian people to the highest possible level really are encompassed in the questions that are posed today.

That is, what is the best arrangement for access to care and what are the services that would be most beneficial to increase access, at the same time maintaining as high as possible quality of medical care during periods when we have to be even more concerned about the cost efficiency of the various programs?

You quite correctly, I think, have identified also that in individual cases these are frequently instances in which differences of opinion may arise because of differences in emphasis.

I have been very pleased with the opportunity to work with you and members of your staff and with the various tribes on this question.

I think everyone recognizes the frustration that I have experienced in the past few years over my own inability to be more supportive of some of the real innovative programs that are being generated in the various communities.

So I look forward to working further on this, I think, very important subject, and I and my colleagues will be pleased to answer any questions that you might have, Mr. Chairman.

[Prepared statement of Dr. Rhoades appears in appendix.]

Senator McCain. Thank you, Dr. Rhoades.

Mr. Human, nice to see you.

STATEMENT OF JEFF HUMAN, DIRECTOR, OFFICE OF RURAL HEALTH, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC, ACCOMPANIED BY CATHY WASEM, R.N.

Mr. Human. Thank you, Senator.

Mr. Chairman, I would like to introduce a member of my staff, Cathy Wasem, R.N. Ms. Wasem formerly directed a nurse training program on the Pine Ridge Reservation in South Dakota.

It is a pleasure to be able to discuss with you this morning the innovative approaches being taken in non-Indian rural areas to address health care needs, particularly with respect to inpatient health care facilities.

Although these innovative approaches are in non-Indian rural areas, I believe much could also be learned by examining how the IHS and the tribes provide integrated services.

Not only does IHS manage a system of hospitals and health centers, it also provides a well-linked constellation of other social and health services: Mental, environmental, public health, home health, and dental.

Further, in many areas, the IHS has developed regionalized systems of care for primary, secondary, and tertiary services.

In addition, the IHS, perhaps more than any other large provider of care, has made effective use of mid-level practitioners; nurse practitioners, nurse midwives, and physician assistants.

The IHS has recognized these practitioners as providers of quality care when used in systems of care, and as providers more likely than others to continue serving Indian people. This is because many of these providers are themselves Indian.

An example of the ability of these providers to address health issues of critical importance to rural areas is illustrated by the situation on the Rosebud Reservation in South Dakota.

When midwifery services were begun at Rosebud, the number of women receiving adequate prenatal care increased from 42 percent in 1983 to 82 percent in fiscal year 1987, and the number of women receiving prenatal care during that period during the first trimester also doubled.

Additional accomplishments of the midwifery service include the integration of the maternity services provided at Rosebud into a regionalized perinatal system and a reduction in the incidence of gonorrhea and chlamydia. Initial data also suggested a decline in the incidence of low birth weight babies.

We in our office work closely with Dr. Rhoades and his staff. We are aware that they monitor carefully what is happening in the private sector that may work well in the IHS as well.

Now, I understand this committee is interested in the possible expansion of IHS facilities, including hospitals. I must tell you that most of the innovative approaches being taken in non-Indian areas by rural hospitals involve downsizing or capacity limiting, developing greater efficiency, or monitoring the delivery system more effectively.

There is also, as I am sure you are well aware, a certain irony in looking to rural hospitals as models of success for Indian facilities.

As you know, rural hospitals across the country are in trouble. Last year, the report of the Senate Select Committee on Aging on this subject estimated that as many as 600 of around 2,500 rural hospitals are in danger of closing.

Hence, success stories from rural hospitals often are stories of hospitals that simply hang on the ledge instead of falling.

The most frequent problem of rural hospitals is that the average daily occupancy in them is too low to generate sufficient operating revenues.

This problem is exacerbated by a number of well-known factors, including low public and private payment levels, high levels of uncompensated care, and problems maintaining competitive compensation for staff.

Only about one-half of all non-Indian rural hospitals receive local tax support. These hospitals have been shown less likely to close than hospitals with no local support.

To respond to these problems, rural hospitals, during the 1980's, engaged in five general strategies. First, they converted inpatient capacity to other uses; second, they downsized their capacity and limited their services; third, they joined together in the hospital systems; fourth, they used personnel innovatively; and fifth, they took strategic planning initiatives and implemented service changes.

I would like to discuss each of these strategies briefly, beginning with the conversions of inpatient care capacity. Faced with declining admissions and declining lengths of stay, coupled with fixed facility costs, rural hospitals have attempted to convert excess hospital beds to other uses.

Perhaps the most popular program of conversion is one that Federal law made possible. That is the swing bed program that allows rural hospitals to convert excess beds to long term care use and then, if necessary, convert them back again to hospital use.

This program emphasizes the flexibility we need to help rural health care institutions survive. Some hospitals have simply converted their facilities or significant parts of them on a permanent basis to long term care.

Other general hospitals have converted to specialty hospitals, for example, substance abuse treatment facilities. A few hospitals have converted to primary care or emergency clinics.

This is less common because the high fixed costs of hospital facilities often cannot be covered by these kinds of services.

A second general strategy of rural hospitals has been to downsize the inpatient capacity and increase their emphasis on outpatient care.

It is difficult for governments, whether Federal or State, to relate to these downsized facilities. Federal and State regulations presume a hospital to include a fixed and fairly rigid set of services and personnel which are not consistent with a downsized facility, which is less than a hospital but more than a clinic.

You may be interested, Senator McCain, to know that until recently Arizona was the only State in the Union that had special flexible hospital licensure requirements for rural hospitals.

For example, rural hospitals in Arizona are not required to have surgical services. They also have less restrictive physician and nurse staffing requirements.

The first attempt to get Federal recognition and support for downsized rural hospitals has been for the Medical Assistance Facility [MAF] proposal in Montana.

The Department is supporting the development of this hybrid of a clinic and a hospital through a grant. The MAF concept is advocated as a health care facility for communities that cannot any longer support a hospital, even a small hospital.

The Montana MAF must be located in a county with less than six residents per square mile in a location more than 35 miles from the nearest hospital. Most of Montana qualifies.

Medical Assistance Facilities provide inpatient care until patients can be transferred to hospitals, and they are limited to providing 4 or fewer days care.

The limit on the length of stay means that they treat only low-intensity or short term acute care patients. They must also have emergency departments.

MAFs can be staffed by mid-level practitioners, nurse practitioners and physician assistants under established protocols and periodic oversight by physicians, similar to the way rural health clinics are staffed.

They can also be staffed by a combination of physician and allied health personnel. The facilities have to pass proposed State licensure and certification requirements that are a synthesis of Medicare hospital and rural health clinic standards.

The modified licensure procedure assures quality services and, at the same time, reduces the regulatory burden for small facilities.

Colorado, Wyoming, Arkansas, and Florida's legislatures now have passed legislation establishing entities that are similar to MAFs.

While we tend to think of MAFs as downsized hospitals, it can work the other way as well. For example, in Colorado, two of the five MAF-type entities are upsized community health centers that previously provided only primary care but now have as many as six holding beds to use for patients who may stay as long as 3 days.

Last year's Omnibus Budget Reconciliation Act included authorization for rural primary care hospitals that are similar to MAFs.

A third general strategy undertaken by rural hospitals has been to form hospital systems. These systems can either be composed exclusively of rural hospitals or they can be anchored to urban tertiary hospitals.

Through economies of scale, rural hospitals can reduce the costs of equipment and supplies. When in systems of care they can share information systems and medical records systems.

A full assortment of services can be provided through the system, although individual hospitals may have limited services. They can offer continuing education programs.

When such systems are anchored to a tertiary hospital, most specialized services can be provided to rural hospitals, including outreach surgery, specialty clinics and telecommunications assistance in diagnosis and treatment.

The fourth general strategy is the use of innovative personnel systems. The patient load at rural hospitals often is so low that it is not practical to employ, for example, both a medical technician and a laboratory technician.

So rural hospitals increasingly rely on cross-trained persons who are skilled in two or more technician fields. Administrative cross-training also is common, thus a secretary may also double as a bookkeeper.

Use of mid-level personnel such as nurse practitioners and physician assistants is reducing the need for physicians in rural hospitals in many States where these professionals can assume considerable independence.

The fifth and last general approach rural hospitals use is strategic planning, followed by implementation of plans. The Federal Transition Grant Program administered by our Department has provided important impetus to strategic planning with grants to hospitals either to plan or to implement plans already made.

Rural hospitals that have received grants have shown special interest in upgrading emergency services and recruiting health personnel.

New York operates a similar grant program with an emphasis on plans to diversify into new services and to form systems of care.

When communities and hospitals plan together, community needs can be explored and prioritized. Hospitals can then develop strategies to meet those needs.

Mr. Chairman, this completes my survey of ways rural hospitals are responding to the needs of their communities to maximize the chances for their own survival and prosperity and to meet community needs. I hope the committee finds this information helpful.

[Prepared statement of Mr. Human appears in appendix.]

Senator McCain. Thank you very much, Mr. Human.

From your knowledge of the IHS, do you believe the swing bed concept could have merit?

Mr. Human. I think there are some limitations on the swing bed concept in the IHS because of the locations in which these hospitals are located and some other limitations as well.

Dr. Rhoades has spoken in the past on this subject, and if you would permit, I feel it would be more appropriate if I would yield to him on that question.

Senator McCain. Dr. Rhoades.

Dr. Rhoades. The term swing beds, in my opinion, at the present time is not sufficiently defined to make an answer very easy.

Most of the time when I have explored this question as it relates to the IHS, it is expressed in terms of putting nursing patients into empty beds in the hospital.

I have been very reluctant, I have refused in the past, to expand the scope of IHS to what in effect is domiciliary care, not failing to recognize the overwhelming concern that there is for providing that kind of care.

My belief is that until we achieve a much greater degree of adequacy of medical services to the community, I believe it would be unwise to venture into nursing care.

Now, I realize that there is a thing called skilled nursing care. I have not had the opportunity to experience where that really places in the program that we now have.

Second, the concern that we have that I do not want to overemphasize, but I want to be sure it continues in the discussion, is that there is a rationale that is offered for utilizing empty beds.

That is a separate issue from my concern of the medical welfare of, let us say, those three patients that are the only inpatients in a hospital at the present time and our ability to provide quality care to those patients.

I have not seen clear evidence—it may be present, and it is worth exploring, I believe—that the addition of another group of patients would increase the quality of care to those few patients that are already there.

So I guess the point I want to make is that there are several goals that are attempted to be accomplished, a major one of which is the preservation of inpatient beds.

That is an appropriate and worthy goal, but I would hope that the discussions will be kept separate so that, in fact, access to care will be increased and quality will be maintained.

Senator McCain. Mr. Human, do you frequently share information about what you're seeing in rural America with the IHS?

Mr. Human. Yes; we do, and I might add that they're quite interested in this on their own, and Dr. Rhoades' key staff read the relevant journals, go to the relevant meetings, and try to keep up with what is happening in rural America as well.

Senator McCain. How effective have your Technical Assistance and Transition Grant Programs been?

Mr. Human. I think it is too early to know to what extent the Transition Grant Program is going to succeed. Certainly, to the extent in the interest that has been shown in it.

There were more than 700 applications last year for the 182 grants that were able to be made, and I think this is one program where simply preparing a grant application is an important step in solving your own problems, because you have to go through some strategic planning and outline where you want to go.

When you look at the awards that were made, we find a heavy emphasis on the establishment of emergency medical systems and on recruitment and retention of physicians and on use of personnel in different ways.

So it would seem that since these are strategies that are often associated with successfully solving the problems of rural hospitals, these would be good strategies and the program is likely to work.

I do not know what you mean by technical assistance. We do have, of course, in the President's 1991 budget an item that indicates that our own office will be doing some technical assistance with respect to rural hospitals, but we are in the planning stages of how we would handle that at this point, and, aside from that, our technical assistance has been pretty much limited to publications on one subject to another and working with the American Hospital Association and others to survey what's going on out there.

Senator McCain. From your relatively objective viewpoint, Mr. Human, do you believe that it is possible to address the issues and challenges of providing health care to Native Americans by coming up with some innovative and new ideas and new programs, at least on a demonstration basis?

Mr. Human. I think that demonstration programs to experiment with new approaches to solving health care on Indian reservations, near Indian reservations, with the tribes is an excellent idea.

I think it is something that the IHS, however, I must continue to try to give them some credit here, has been doing for some years, and, in particular, the use of nurse practitioners and nurse midwives and physician assistants as extenders of physician care is one area in which I believe the IHS has achieved leadership that could be copied by the private sector.

Senator McCain. Thank you.

Dr. Rhoades, what is the current backlog of facilities on the priority list in terms of numbers of facilities and numbers of years to get them built at the present rate?

Dr. Rhoades. Let me ask Mr. Pearson, who should have that information readily available, Mr. Chairman.

Mr. Pearson. Mr. Chairman, on the present facility priority list that we have, which consists of three priority lists, one for hospitals, one for health centers, and one for staff quarters, there are 10 projects for outpatient facilities, nine projects for inpatient facilities, and four projects for staff quarters.

We do not have the total cost on all of these. We are doing preliminary cost estimates and engineering studies on at least four of these projects.

At this point, the total remaining cost on most of those projects, with the exception of three or four that we are doing studies on, is on the order of magnitude of $435 million.

Senator McCain. About $435 million?

Mr. Pearson. Yes; $435 million.

Senator McCain. About how much annually have you been receiving for these projects?

Mr. Pearson. Annually, on the order of magnitude of $18 million to $30 million.

Senator McCain. From $18 million to $30 million?

Mr. Pearson. Yes, sir.

Senator McCain. From $18 million to $20 million or $18 million to $30 million?

Mr. Pearson. From $18 million to $30 million.

Senator McCain. So in the best case scenario it would be about 12 years? That would be the best case under current funding levels?

Mr. Pearson. Yes, sir; if the historical trend continued, it would be on the order of magnitude of 10 to 13 years.

Senator McCain. Thank you.

Dr. Rhoades, you mentioned in your statement that the IHS cannot, within current policy, provide funding for the staffing and operation of a new or expanded tribal health facility which is obtained using non-IHS funding. Is that correct?

Dr. Rhoades. That is correct.

Senator McCain. Would you like to have the authority to get that kind of flexibility which you do not presently enjoy?

Dr. Rhoades. In my opinion, it would be desirable to have that authority. I need to hasten to add, of course, that would not lessen the importance of the question that you just asked Mr. Pearson as well, that a series of decisions will still need to be made, even though we have that authority.

That will carry us further, but it will not solve all the problems that exist.

Senator McCain. Can you lease a facility from a tribe?

Dr. Rhoades. Yes; we now have the authority to lease from a tribe. My understanding is, based upon the language from Congress, that in the case of an initial lease, we do not have the authority to enter into an initial lease without prior approval and express consent of the United States Congress.

The reason for that, I believe, is to maintain some degree of order in relationship to the staffing requirements that always come up in relationship to those facilities as well.

Senator McCain. As is well-known in Indian country, you have a closure list, and with regard to that list you have been, frankly, in my view, very helpful by not implementing, at least at this time and recognizing that you cannot hold off forever, given budgetary constraints, the recommended closures. Is that an accurate statement?

Dr. Rhoades. I believe that is an accurate statement, Mr. Chairman. I would like to add that, in reference to a statement that you made in your opening remarks as well, you correctly identified the fear in the community that closure of inpatient beds represents a diminution or even a likelihood of diminution of services.

Obviously, that must not happen. I do believe that in some of our facilities where the average daily patient load is greatly exceeded by the support staff in that hospital that, in fact, we are denying access to individuals now by keeping those beds open, and I am concerned about that denial.

Second, I think it would be fair and appropriate for me to express that I do believe that in surveying the causes of death of Indian people and the causes of morbidity of Indian people, which this committee has done very well in addressing and elucidating in the past, and if we just take the three leading causes of death of Indian people, heart disease, injuries, and cancer, and then if we go to the next, diabetes, alcohol and so forth, the great need, and I think it is expressed by the evolution of IHS, is not for inpatient beds, but it is in services in the community, which is where IHS has been.

I hasten to add that I do not offer that as an either/or situation, but the appropriate approach, I believe, has again been expressed by Dr. Emery Johnson, that the approach should be, in my opinion, to go into a community, do the appropriate thing which, in the Aberdeen area, is called the PATCH approach, the Planned Approach to Community Health, with local epidemiology, what is it that is really damaging the people there, and then devise the technique that best approaches a solution to that problem.

The technique might, in fact, be more inpatient beds, but very often the technique may, in fact, not be more inpatient beds, and I guess I just want to keep that open as we go forward, and we will have to continue to consider the appropriateness of very low utilization of some of our inpatient beds.

Senator McCAIN. Can you continue your moratorium, at least in the near term?

Dr. RHOADES. I am sorry, I did not hear all of that.

Senator McCAIN. Can you forego your closures, at least for a while, until we get some of these issues sorted out?

Dr. RHOADES. Yes; and I want to be sure and add that for some facilities there is a pipeline in effect, and everyone needs to understand that would be held back as well. But, yes, I think it would be inappropriate for me to charge ahead at this particular time.

Senator McCAIN. Thank you. Finally, I know of your personal interest and commitment to wellness, and you've already mentioned that you currently have the authority to explore this area by allowing the construction of facilities for wellness activities and the implementation of wellness programs?

Dr. RHOADES. I am not sure whether we have.

Senator McCAIN. So that would be another area that you would like to have the flexibility to be able to get into?

Dr. RHOADES. That perhaps might be a little premature. Let me just phrase it this way. I believe that is perhaps one of the most intriguing possibilities that exists at the present time, and I certainly would like to participate in the exploration of that.

Senator McCAIN. Perhaps another demonstration kind of project?

Dr. RHOADES. On the spur of the moment, that would seem to be a possibility

Senator McCAIN. I thank you both for joining us this morning, and I cannot overemphasize the critical nature of this issue of providing a minimum level of health care to our Native American population, and I appreciate the commitment that both of you have to that goal, and I look forward to working with you this year in hopes of getting some legislation so that we can better provide for these unmet needs. Thank you very much.

Our next panel is Bernard Bouschor, who is the chairman of the Sault Ste. Marie Tribe of Chippewa Indians; Lorraine White, president of the Quechan Tribal Council of Yuma, AZ; and James Paiva, who is the chairman of the Shoshone Paiute Business Council. Welcome.

Ms. White, you may begin.

STATEMENT OF LORRAINE WHITE, PRESIDENT, QUECHAN TRIBAL COUNCIL, YUMA, AZ

Ms. WHITE. Certainly, thank you.

Mr. Chairman, fellow members of the Senate Select Committee on Indian Affairs, ladies and gentlemen, my name is Lorraine White.

I am the president of the Quechan Indian Tribe from the Fort Yuma Reservation near Yuma, AZ. I have the honor to address you today concerning a matter of great importance, the proposed closure of the Fort Yuma Indian Health Service Hospital.

The Quechan Tribe is very concerned and strongly opposes the proposed closure. We have many concerns, but they all may be summed up in one major point.

Regardless of the studies and projections made by the IHS Administration, the proposed closure will result in lower quantity and lower quality health care for my people.

Contract health care funds routinely run out before the end of each funding year. The result has been that contract health care services are available only as long as the funding lasts.

For instance, in fiscal year 1989, the contract health care funds for the Phoenix area were depleted by August 15, 1989.

The IHS advised all service units to restrict their use of contract health care dollars to emergency situations only.

Shifting of funds to contract health care funding to increase the funding level will result in some inpatient services that are now available at the Fort Yuma Indian Hospital being made less available or even unavailable in order to conserve funds.

This may result in little or no inpatient care being available near the end of the funding year. Either situation would result in serious negative consequences.

We are also concerned about the different admission and discharge standards which will be in effect at the Yuma Regional Hospital.

Yuma Regional Hospital utilizes a diagnostic-related grouping standard for admission and discharge. The diagnostic-related grouping standard is less personal than the standard in use at the Fort Yuma Indian Hospital.

The Yuma Regional Hospital is not oriented to either Indian culture or special Indian medical needs and excludes factors which have been found to be important in determining admissions and length of stay at the Fort Yuma Indian Hospital.

There are two types of admissions practiced at Fort Yuma Indian Hospital which are not included in the system in use at Yuma Regional Hospital, the prevention-oriented admission system and the social admission system.

The prevention-oriented admission mainly occurs in diabetes-related cases, and I am sure this committee is aware Indian people in the southwest suffer from diabetes at a much higher rate than the general population.

Currently, when a person has diabetes-related wounds, instead of being sent home the person often is kept under supervision at the Fort Yuma Indian Hospital until any immediate danger of infection is over.

Furthermore, people either recently diagnosed with diabetes or in need of further education often are allowed to stay at the hospital and learn and apply new eating and exercise habits while removed from their usual environment.

This admission practice has helped prevent the advancement of the negative affects of the disease, and people's conditions have improved.

The social admission occurs where a person's social circumstances either may aggravate a physical condition or may prevent a condition from subsiding.

This can occur in a variety of circumstances, including cases where elders live alone and need outside assistance, where pure drinking water is unavailable, and where child abuse has occurred.

In these cases, more drastic action and more extensive treatment often can be avoided by admitting the affected person to the Fort Yuma Indian Hospital and allowing for an extended stay.

These types of admissions and the extended stay policies found at the Fort Yuma Indian Hospital are an important part of health care services in our community, yet neither will be available at the Yuma Regional Hospital.

Furthermore, the number of beds available at the Yuma Regional Hospital often are quite limited, especially during the winter months, when large numbers of elderly people visit the Yuma area.

We feel that this will only exacerbate the negative impact of the different admissions and length of stay policies at the Yuma Regional Hospital.

The Quechan Tribe is also concerned about certain cultural aspects pertaining to treatment at the Yuma Regional Hospital.

When Quechan people are ill or dying and staying at the Fort Yuma Indian Hospital, family and friends are allowed relatively free access.

This is very important for the patient, family and friends. This type of culturally significant accommodation would not be allowed at the Yuma Regional Hospital.

The staff at the Yuma Regional Hospital are not as knowledgeable of and as sympathetic to the cultural differences of Indian people as are the staff at the Yuma Indian Hospital.

The doctors and nurses at the Yuma Regional Hospital are not as familiar as those at the Indian Hospital with medical conditions which are prevalent among Indian people but relatively rare in the general population.

Another major problem with the proposed closure is lack of transportation. The Fort Yuma Indian Hospital is located on our reservation, but the Yuma Regional Hospital is located approximately 15 miles away.

Many people can walk to the Indian Hospital but will not be able to walk to the Yuma Regional Hospital. The Community Health Services personnel provide transportation to the Indian Hospital when needed, but current regulations will prevent them from transporting people to the Yuma Regional Hospital.

There is one final consideration which has been overlooked by the IHS Administration, and that is how the Quechan people feel.

The Fort Yuma Indian Hospital has been on our reservation for over 60 years. The Quechan people have grown up with the hospital. They depend on it. It has become an important part of the community.

The policy of the U.S. Government is to promote self-determination for Indian people and to heal the wounds Indian people have suffered as a result of past bureaucratic insensitivity.

The closure of the Fort Yuma Indian Hospital against the Quechan Tribe's wishes will help to achieve neither of these things.

Last, today the committee is holding this hearing to consider the development of legislation to include expanding the IHS definition of a health care facility to include alternative health care systems.

I hope that the testimony I have presented will assist you in recognizing that alternative systems are necessary and needed in Indian communities.

Thank you for providing me the opportunity to address you today. I will be glad to answer any questions.

Senator McCain. Thank you very much.

[Prepared statement of Ms. White appears in appendix.]

Senator McCain. Bernard Bouschor is the chairman of the Sault Ste. Marie Tribe of Chippewa Indians.

Welcome, Mr. Bouschor.

STATEMENT OF BERNARD BOUSCHOR, TRIBAL CHAIRMAN, SAULT STE. MARIE TRIBE OF CHIPPEWA INDIANS

Mr. Bouschor. Good morning. We have prepared a statement we will be submitting for the record indicating our needs for outpatient health facilities, and it is appropriate that your committee is looking at the issue of rural health delivery systems.

The tribe, in the past few years, attempted to work through the Federal Government in obtaining an outpatient clinic in the 638 document in the Indian Health Education and Self-Determination Act, and it took us 8 years to complete that process.

In that process, when the outpatient facility was under IHS supervision or control, they did a study as to what were the barriers of the health center as compared to the Sault Ste. Marie Tribe population centers.

The problem with the facility was the access to the site. It was located on an old, closed air base 25 miles from the closest population centers.

It was convenient at the time to provide health care for delivery of the services at that facility, but with the study they found that the utilization rate was less.

The fact that the tribe has two types of health care systems, contract health care dollars and now an outpatient clinic, we have required, because the tribe has been basically under a Priority One system for 3 to 4 years, that all tribal members within 100 miles of the area go to the outpatient clinic facility first.

The tribe has a relatively large service population that uses the facility. The utilization is considerably lower than what the IHS National average is, and the reason why is because the facility itself, through the geography and the present staffing, has a limited amount of time available in which to see tribal members for health care.

This turns out to be a negative from the standpoint of the tribe, because the distance is a factor, the requirement that everybody use the facility is another factor.

Utilization is subsequently used in allocating new resources that come down through IHS through the equity distribution system, and they also use it with contract health care, and it shows that there is not as much need based on tribal population as the average within IHS might be.

The major factor in the lack of utilization is the distance involved to the facility, the fact that we've been on Priority One for 3 years.

We have restricted the type of services that we could provide, we have denied health care that is not a Priority One service, individuals that may receive assistance in their contract health care are later denied assistance under that type of system.

So this is what we were faced with at the time we were taking over, plus we were aware that IHS was looking at the facility and relocating it when the tribe acquired it under the 638 process, we chose to then continue the process of planning to relocate it closer to the tribal population centers.

In that endeavor, we looked at various methods of alternative financing available to the tribe, not aware that there was a restriction that was developed through the appropriation process that would forbid the process that the tribe was going into.

The tribe was looking at the Indian Tax Status Act, the process of selling Governmental bonds that basically will put the tribe in debt for whatever number of years it takes to build a facility, and we were willing to do that, but then as we started talking more with IHS, we found that there was a barrier to actually proceeding with that from a tribal standpoint because of the restrictions in the appropriation process.

We planned to build an outpatient facility, we planned for the current needs, taking all of our existing health services and consolidating them in one building, which we have not been able to do up to this point.

We looked at the cost associated with it, we planned for the future so we'd have some capacity for purposes of increased usage of the outpatient facility.

We did not get into a lengthy discussion in the paper about the innovative approaches that we are doing with tribal health care.

Like other tribes, we do things that are, well, maybe unique to our area, but we do not really know, because we have not shared it on a nationwide basis with other tribes.

But we need to look at that barrier. The tribes, as a process of tribal government, should not be restricted in developing a better method of delivering health care to tribal members.

In respect, that is what we are doing. We are denying adequate health care because IHS, based on policy, or maybe it is appropriations, is saying it is tying up additional physicians or services or staff, and as a result of that, you can't build a facility closer to your population centers.

But we will leave the barrier there for the transportation distance, we will require everybody to go there within 100 miles, we will continue to deal with inadequate budgets, both for competent health care and the outpatient facility.

We cannot provide you money for developing a transportation system to the clinic, you know, which would assist, but you need the staffing to provide the assistance.

So we are kind of caught in a circle that we cannot seem to get out of. We need the assistance of your committee and the legislators to correct that.

We will do whatever we can to assist you in that adventure we might go into. We are committed to making changes, we worked at issues for a considerable number of years, and we will be willing to give our support to you on this one.

We think it is necessary and it is appropriate at this time. Thank you.

Senator McCAIN. Thank you very much, Mr. Chairman.

[Prepared statement of Mr. Bouschor appears in appendix.]

Senator McCAIN. Our next witness is James Paiva, chairman of the Shoshone-Paiute Business Council.

Welcome, Mr. Chairman, and would you identify the two individuals you have with you.

STATEMENT OF JAMES PAIVA, TRIBAL CHAIRMAN, SHOSHONE-PAIUTE BUSINESS COUNCIL, ACCOMPANIED BY LINDSEY MANNING, TITLE STAFF; AND JAMES MAY, CONSULTANT

Mr. PAIVA. Yes, Mr. Chairman. I have with me Lindsey Manning, title staff, and I have Jim May over here, a consultant.

When we got your letter of an invitation to this hearing, we got so thrilled that we prepared a 30-page statement, but I am going to summarize it in three pages.

Senator McCAIN. Please know that your entire statement will be made part of the record and will be read by me, the other members of the committee and the staff, and we appreciate all the hard work that must have gone into it.

Mr. PAIVA. Thank you. It is an honor and a privilege to be here today before you. We at Duck Valley have been struggling to fully utilize our hospital but have been hampered by IHS restrictions and definitions.

We have a beautiful $4 million hospital which was completed in 1976. It contains a fully equipped 15-bed inpatient capability, outpatient clinic, X-ray, laboratory, minor operating room, OB ward, dental, pharmacy, emergency room, administrative offices, and related facilities.

IHS has also numerous apartment complexes located near the facility for service personnel. The Duck Valley Indian Reservation is located in what has been termed as the west's forgotten corner, a remote area 100 miles from Elko, Nevada, to the south, and 100 miles from Mountain Home, Idaho, to the north.

Our hospital has been invaluable to the life and limb of the Indian and the non-Indian of this remote region. We have a public school on the reservation which is attended by over 400 students.

Our reservation is the hub of the adjacent ranches and mines for community health and other services. The Phoenix area office of the IHS has slated our community health hospital for closure without what we view as the proper considerations.

Their rationalization overlooked several important factors and was without merit, in our view. Their tunnel vision and fiscal needs elsewhere dictated to them the closure of our inpatient and 24-hour emergency care along with the relocation of professional service people.

We called upon with success the intervention of our Congressional representatives for a stay of the closure until we were satisfied that we were not being railroaded as a sacrificial lamb and that our needs are properly addressed.

We are now and have been seeking an innovative approach which will fully utilize the hospital for the Indian and the non-Indian of the region.

We would like to go beyond the IHS definitions and constraints for an effective health care delivery plan and perhaps long term rehabilitation, convalescence and specific therapy treatments.

Of the 15 beds available at Duck Valley, 12 are designated for adult, two for pediatric, and one for infant usage.

IHS requires extensive paperwork should a bed not be utilized for its designated purposes. Perhaps a swing bed, changing definition of bed usage, could be implemented through this demonstration program.

We would like to hereby request that the Shoshone-Paiute Tribes of Duck Valley become a part of this 5-year demonstration project to present an alternative to the current IHS definition of a rural health care facility.

Presently, we are seeking funding through IHS and perhaps by the proposed legislation to conduct the Full Utilization Study of our hospital.

We feel that we would be able, within the next 5-year demonstration period of the proposed legislation of Senator McCain, to determine the most cost effective means as well as enhanced health care delivery.

Whereas now a non-Indian visit to the outpatient clinic costs at a minimum $76 per visit by IHS standards, we feel we would be able to cut that cost to the user.

A cost per treatment rate would be substantially less and more attractive competitively. New money from enhanced third party service delivery would result in an innovative scenario.

We would not be looking to discredit the IHS but would be seeking to enhance it with our tribal government's involvement.

The tribes of the Duck Valley Reservation would be working with the IHS rather than in the adversary role we have been associated with in the past.

Our specific request to become a part of this demonstration project does not involve facilities construction funds, but rather an innovative approach to fully utilize our rural health care facilities for the Indian and the non-Indian of this remote region.

We are 100 miles from the nearest Safeway store, we have numerous ranches and miners of non-Indians, and our hospital was built in 1976.

I summarized that 30 pages into 3 pages, and I would like to give some of my time to Mr. Jim May.

Mr. MAY. Thank you. I am a contractor for Rural Health Systems Design and Management and have been so for some time. I come to this issue without prejudice, because I have not worked with the IHS, nor have I worked with any other tribal council before.

I got involved about 1 year ago because of the work that we are doing with redesign development and management of troubled rural health systems, non-Indian health systems.

Jeff Human mentioned earlier some of the reorganizational changes that are going through and the success stories in other rural hospital situations.

I was asked by the Fort Belknap Tribe, through the attorney, after some discussions with Mr. McIntyre at a meeting, would some of those reorganizational changes be appropriate for the reservation health care system, and I developed a proposal for a feasibility study for Fort Belknap.

To be very brief, I can find relatively few differences between the health care plan necessary to provide the breadth of services that they can afford at the level of quality that we can maintain for these situations as I have been dealing with, with other rural hospital situations.

Issues like skilled nursing, for instance. Skilled nursing beds are typically not used to fill up beds; they are used as a response to the way Medicare and Medicaid pay for geriatric services for acute care patients, and that is, with the advent of DRGs for the payment source, for rural hospitals it reduced the number of days that most diagnoses could be kept in the hospital, although the patient did not know that.

The patient still could not go home and needed medical care. The legislation was passed to allow for swing beds, which allows a patient who must have medical supervision and must have some sort of a facility of skilled nursing to stay in the hospital.

Hospitals get paid less for it, but by definition, they are not custodial care. The system that we are looking at for these two locations is not innovative in the real world, it is innovative in providing services, the ones that I see, for the two reservations that I have been dealing with.

It is an application of tried and true methods to salvage rural health care systems. The systems that we are dealing with, with the two tribes that I am working with have the basic needs that all other systems have, except they had to reorganize after 1982 in order to survive, and they have made the same changes that I think we could make with these health care plans for these people, both at Fort Belknap and Duck Valley.

I think quite frankly that it will work, but it would call for a change of the face of the facility and probably an increase in the scope of services and a decrease in the depth of service, so that we have the maximum number of services that we can afford on site, and we provide those services at the highest level that we can assure quality.

I will entertain any questions, but that would be the extent of my comment.

[Prepared statement of Mr. Paiva appears in appendix.]

Senator McCAIN. Thank you very much. I thank all the witnesses for your very important statements.

Chairman Bouschor, do you envision that new facility of which you spoke to be an IHS-owned facility or a tribally-owned and IHS-leased facility, or have you gotten that far in your process of planning?

Mr. BOUSCHOR. It is a tribally-owned facility. At the present time, we have a 638 contract with the outpatient clinic. That occurred in 1988.

We were proposing to build the facility, the tribe was going to build it, and we were going to lease it back through our existing programs that we have, but there was not anything that was requiring, we did not feel at the time, IHS to do this.

But then we ended up finding this problem that occurred with the appropriation language.

Senator McCAIN. Chairman Bouschor, do you envision the service population to be composed of non-Indians as well as Indians?

Mr. BOUSCHOR. There will be some limited care there, but the primary service is to tribal members. The community can use it, it is open, and there will be a charge back to them to use that service through third party billings.

The facility is presently JCH-approved, and we would expect to maintain that status in order to, I guess, supplement some of the existing programs that we are operating.

Senator McCAIN. So if the tribe decided to service non-Indians as well as Indians, it would basically help defray some of the costs?

Mr. BOUSCHOR. Well, that would be some of the planning involved with it. The cost associated with the facility would be borne by the tribe through the bonding process.

The rest will provide services to the community, but the primary service is to the tribal community, because that is where the need is.

Other community members can use the facility, and it is open to them, as they are with most other facilities.

Senator McCAIN. Well, I think you and the tribe have been very resourceful, and we want to do what we can to add some flexibility to help you out in every way we can.

Mr. BOUSCHOR. Thank you. I have one question. When Dr. Rhoades was talking, the moratorium on the closures of existing hospitals, did I misunderstand it?

Is there also a moratorium on the construction of new facilities with this moratorium? Does it hit both ends?

Senator **McCain**. No; is that true, Dr. Rhoades? There is no moratorium on construction, is there?

Dr. **Rhoades**. Maybe I better ask Mr. Pearson if he would address that.

Mr. **Pearson**. Mr. Chairman, in response to the question of the Senate, we did put a temporary moratorium on any further application of the health facilities priority system to put new facilities on priority lists until the Senate has had a chance to explore this issue further.

It was our understanding that the Senate wanted to consider alternative innovative facilities, and that before we proceed and put projects on the priority list, the Senate would like to have the opportunity to look at these alternative innovative facilities and give recommendations to us.

But we have, yes, put a temporary moratorium on the application of the health facilities priority system.

Senator **McCain**. Does that answer your question?

Mr. **Bouschor**. Does that mean the ones that are presently funded are ongoing? They are just saying those that are not on the list are not going to be reviewed at this point?

Senator **McCain**. It is an affirmative answer. Yes.

Thank you, Mr. Chairman.

President White, how many beds are at your hospital?

Ms. **White**. We have 17 beds.

Senator **McCain**. And the average patient load?

Ms. **White**. The average patient load is, let me see, approximately six per day.

Senator **McCain**. What is the effect on the Yuma Regional Hospital of the so-called snowbirds?

Ms. **White**. Every winter, it has a shortage of beds.

Senator **McCain**. So if there was a closure, of the Hospital of Fort Yuma, in the winter time you would have difficulty receiving service at the Yuma Regional Hospital?

Ms. **White**. That is our feeling, yes.

Senator **McCain**. Thank you. As you know, I have had the pleasure of visiting you, and I would be glad to come back, and hopefully we can help with this very difficult issue you are facing.

Ms. **White**. Thank you very much.

Senator **McCain**. Chairman Paiva, what is the current utilization rate of your existing facility?

Mr. **Paiva**. The average daily patient load is 2.4. I have a 15-bed facility.

Senator **McCain**. If your facility were closed, where would tribal members go to get care?

Mr. **Paiva**. That would mean a 100-mile trip one way to either Mountain Home, ID, or Elko, NV, so if you could leave at all, it would depend on the weather.

The valley floor is 5,400 feet, our growing season is 90 days, so we are mostly in bad weather.

Senator **McCain**. It is my understanding this facility was built at a cost of $4 million in 1976. Is that correct?

Mr. **Paiva**. That is correct.

Senator **McCain**. If it was closed, what would this facility be used for?

Mr. PAIVA. Essentially, you would be mothballing 90 percent of the building. It is a brand new facility, it has an X-ray room, a pharmacy, a dental clinic, OB ward, the whole 9 yards are there, and it seems like such a waste not only for the Indian people, but for the non-Indians of the remote region.

Senator MCCAIN. What rationale was given to you for the proposed closure?

Mr. PAIVA. The proposed closure was actually Fort Yuma of the Phoenix area and our facility, the two smallest service units.

Senator MCCAIN. What reason did they give you? Any other reason besides budgetary?

Mr. PAIVA. The average daily patient load was the reason that they gave us. Like we mentioned in our testimony, we felt our health was being sacrificed for fiscal restraints.

I think I would like to say something here that has to do with the budget. There's never enough money for anything. I realize that.

But our needs grow annually, IHS has a fixed budget, and every time that a budget comes in, it is always less. There was a $14 million shortfall in the Phoenix area last year.

But when we get the shortfall, our contract health dollars are cut, and they cut corners on everything except themselves.

The Pay Act increases survive Gramm-Rudman, they survive everything. So when we get so many dollars for our service unit and the Pay Act increases take effect, it moves in offsetting proportion like that.

Nothing against the Commission Corps, but we have nurses that make more than practicing physicians because of the longevity and their resumes and all this other stuff.

I feel I have to say that, not to degrade IHS, but it seems like we are in a losing deal here.

Senator MCCAIN. I understand. Thank you.

Mr. PAIVA. Mr. Chairman, I would like to add a little bit about closure on Duck Valley. We've got a low inpatient load mostly because our beds are not utilized.

We as Indian people and as tribal leaders, our people are sent to Boise, ID, 140 miles away, and under contract health care, they are being held there, and we have got a hospital here that is fully staffed, and we cannot see the need for our people to leave the reservation.

Even the chronically ill are sent off, and our patient load is a lying statistic, because the use of the beds are not being utilized. I would like to add that in the record.

Senator MCCAIN. Thank you very much, Mr. Chairman.

Thank you all for the advocacy of the people that you represent, and thank you for coming a long way to be with us, and we look forward to working with you and seeing you in the future. Thank you very much.

Senator MCCAIN. Our next panel is Mr. Pat Racette, who is the director of the New Day Treatment Center at the Keweenaw Bay Indian Community, and he will be accompanied by Mr. Charles Loonsfoot, who is a tribal council member; Dale Riesling, who is the chairman of the Hoopa Valley Business Council of Hoopa, CA;

and Allen V. Pinkham, chairman of the Nez Perce Executive Committee of Idaho.

For the record, I am informed by staff that Mr. Jasper Hostler is here representing Mr. Dale Riesling.

Is that right, Mr. Hostler?

Mr. HOSTLER. Yes, sir.

Senator MCCAIN. What is your title?

Mr. HOSTLER. I am the vice chairman of the Hoopa Valley Tribe, sir.

Senator MCCAIN. Thank you for joining us this morning.

Mr. Racette is here, and Mr. Loonsfoot is with you. Welcome.

Please proceed with your testimony, Mr. Racette, and welcome.

STATEMENT OF CHARLES LOONSFOOT, TRIBAL COUNCIL MEMBER, ACCOMPANIED BY PAT RACETTE, DIRECTOR, NEW DAY TREATMENT CENTER

Mr. LOONSFOOT. Mr. Chairman, I would like to make an opening statement for the Keweenaw Bay Indian Community.

Mr. Chairman and members of the committee, we thank you for the opportunity to provide testimony on the concerns of the Keweenaw Bay Indian Community Indian Health Service facility.

My name is Charles Loonsfoot, I am a tribal council member and also a counselor at the New Day Treatment Center facility. Our tribal chairman could not be here today, due to a family illness.

Pat Racette is going to be summarizing about our facility. As part of the Council in the community, this is our top priority for the Keweenaw Bay Indian Community.

We have been working on this problem for about 3 years, and prior to that, we have been trying to come up with some different fundings and different stuff like that, but we have basically come up against a brick wall.

Because of the priority system that we are under, we are a small tribe, and we can't even basically get on a priority system.

I would like Pat now to summarize the rest of our statement.

STATEMENT OF PAT RACETTE, DIRECTOR, NEW DAY TREATMENT CENTER, KEWEENAW BAY INDIAN COMMUNITY, BARAGA, MI

Mr. RACETTE. Mr. Chairman, members of the committee, on behalf of the Keweenaw Bay Indian Community, we would like to thank the committee for scheduling this hearing to investigate the problems associated with construction of IHS and tribal health care facilities.

We feel that unless something is done to assist tribes such as Keweenaw Bay, it is doubtful that we will ever solve our health care facility crisis.

The New Day Treatment Center and the Indian Health Clinic, and also a number of other tribal programs, are housed in a building that was constructed in 1928.

It was originally designed as an orphanage. It was never built for what we are trying to use it for. This was donated to the tribe in 1970.

The treatment program, however, started in 1974, along with the Tribal Health Clinic and other tribal programming. In 1979, the building was condemned by the Michigan State Fire Marshal; however, due to the fact that the State did not have jurisdiction, the tribe was forced to continue its use of this facility, because there are no other resources available.

Some of the problems that are associated with this building are just the old plumbing, inadequate lighting, heating.

The New Day Treatment Center is licensed as a 20-bed facility. We have had clients in the middle of winter wrapped in blankets because we did not have any water, which is our main source of heat.

We have also had to haul water. We do have a good rapport with the community, however, and have utilized them in these crisis situations for showers and for other necessities.

The tribe, in 1985—and even prior to this, were looking for other resources—identified this as a new building to house the medical clinic and alcohol treatment center number one priority for the tribe.

The tribe has been able on its own initiative to come up with in excess of $1.4 million. In 1989, we came to Congress to try to get cost sharing and/or Congress to help with cost sharing, and found out they could not do this.

Some of the moneys that I believe are important that the tribe has been able to initiate is from the tribal resources themselves at $200,000, HUD at $250,000, the Kresge Foundation at $500,000, IHS water and sewer at $35,000, Michigan Office of Substance Abuse Services identified $100,000, and working with Senator Jacobetti, of the Appropriations Committee, he was able to have the State of Michigan appropriate $500,000 for this facility.

Basically, we are here today to address this committee and identify the need for help, but we are in a unique situation.

We have tried to go the route that is established. The IHS facility priority list does not work for Keweenaw Bay, and we do not feel it works for other small rural populations because it is a numbers driven system, and if you cannot come up with the numbers, you can't get on the list. it is as simple as that.

With Keweenaw Bay, the uniqueness is that we do not need extra staffing. We have highly professional staff and we do not suffer from utilization problems.

In fact, our utilization last year was approximately 83 percent, and as we left for this meeting, it was 110 percent. There is a high demand for substance abuse services.

In fact, why it is 110 percent, I think, is very interesting. As we are limited to 20 beds, we have a very high priority concerning community people, and even though we are full and a community member wants to come in, we are going to find room.

We had a situation 1 week ago last Monday, that we were called by the Tribal Center in Dowagiac, MI, which is down closer to the Indiana border, that a person wanted to come to treatment and had left on his motorcycle, and he was not on our list.

Friday, he got there. His motorcycle had broken down, and he hitchhiked for 4 days and made it to the unit. There was no way we could not give him services.

So what we did is we violated some of the rules of the State of Michigan by squeezing another bed, but we did it. We thought it was necessary.

So some of the needs that we have are increased capacities or the ability to increase our capacity when it is necessary.

We presently have a 6-week waiting list. We feel a need for the treatment center and Tribal Health Clinic to be together due to the fact that we utilize each other, and we work closely with mental health within the treatment process, the medical and mental health are a part of a team approach that we utilize.

If there were increased needs of staff, a new facility would enable us to have third party reimbursement, and we would utilize those resources for staff increases if it was necessary.

Other barriers that the Keweenaw Bay Tribe have encountered under the existing law pertain to construction of IHS facilities and non-IHS funds.

We strongly urge that Congress enact new legislation to authorize tribes to pursue a cost-sharing approach to the construction of IHS and tribal health care facilities.

We recommend that this approach be tested on a pilot basis for those tribes that under tribal self-determination wish to exercise this option of cost sharing.

Authorizing a limited number of facilities under a second priority system would enable Congress to evaluate the relative costs and benefits associated with cost sharing.

It will be absolutely critical, however, to authorize and appropriate, as I have heard mentioned before, additional facilities construction funds for this purpose, because we do not want to detract from the progress that is being made under the existing facilities priority list.

If the committee were to develop legislation authorizing cost-sharing of construction funds, it must be emphasized that this is not meant to replace or diminish the Federal Government's responsibility to those tribes that do not have resources to raise funds for facility construction.

With that comment, I believe that we are stating that there are tribes that have lesser resources than we do. We are aware of that, and they need to be taken into consideration.

We also recommend that the alternative priority list evaluate the need for facilities as well as any innovative health care delivery systems which will be provided by tribes.

In summary, Mr. Chairman and members of the committee, thank you for the opportunity to testify on the problems associated with IHS facilities.

We appreciate your concern and interest in our problems, and we urge this committee to develop legislation to assist Keweenaw Bay and tribes in similar situations to develop a workable solution to meet our health care needs and stand ready to work with you to resolve these problems. Thank you.

Senator McCAIN. Thank you very much, Mr. Racette and Mr. Loonsfoot.

[Prepared statement of Mr. Racette and Mr. Loonsfoot appear in appendix.]

Senator McCain. Next we will hear from vice chairman Jasper Hostler.

Mr. Vice Chairman, would you identify anyone who is accompanying you?

STATEMENT OF JASPER HOSTLER, JR., VICE CHAIRMAN, HOOPA VALLEY BUSINESS COUNCIL, HOOPA, CA, ACCOMPANIED BY PETER MASTEN, EXECUTIVE DIRECTOR, HOOPA HEALTH ASSOCIATION; GEORGE KOORTBOJIAN, ST. JOSEPH HEALTH SYSTEM; AND VIC BISWELL, ASSOCIATION OF CALIFORNIA HOSPITAL DISTRICTS

Mr. Hostler. Good morning, Mr. Chairman. My name is Jasper Hostler, and I am the vice chairman of the Hoopa Valley Tribe.

I have with me Mr. Peter Masten, who is the executive director of our Hoopa Health Association. Also with me is George Koortbojian, who is from the St. Joseph Health System in Eureka, and also Mr. Vic Biswell, from the Association of California Hospital Districts.

Senator McCain. Welcome to all of you.

Mr. Hostler. We are currently conducting a feasibility study to draw up a comprehensive health care plan. On behalf of our tribal council and our tribal members, I would like to thank you for the opportunity to testify.

I want to commend you for your foresight in recognizing and including Indian Health Service Priority Construction and Renovation methodology.

The Hoopa Valley Tribe wants to join you in your demonstration project that would increase the rural health services to small tribes like Hoopa.

We believe the recent reduction in medical services has created a situation that is ready-made for development of a demonstration project.

The local hospital was closed in 1988. We immediately started to explore options to restore those critical services. We are currently conducting a feasibility study to restore our dominance of health care.

Although not yet completed, we have documented some renovation costs. At the completion of the study, we expect renovation costs will be identified.

I might add the hospital is owned by a local community health association and managed for profit by private enterprises, and they did not meet their financial objectives, which led to the closure of the facility.

At this time, the tribal council took initiatives to bring together both the current and prior providers to seek solutions for the health care needs of the tribal community population.

We have been successful and obtaining the hospital facility and the land on which it sets. In addition, we have also caused the State Licensing Bureau to transfer the hospital license to the Hoopa Valley Tribe.

As I mentioned before, we are currently conducting a feasibility study for the identification and development of future appropriated services.

Our present health care problems are acute. Today, there are no emergency room services or inpatient health care on our reservation or in the community.

For major health care, the patient must be transported to a coastal city some 60 miles away over winding and twisting roads, traversing two mountain ranges.

There are many days when snow and slides have closed the roads. The Hoopa Valley Tribe knows that our community will get the basic services only if the problems are addressed and solved ourselves.

We have formed an ad hoc committee, which I chair, to develop a responsive plan. Please be assured that the Hoopa Valley Tribal Council is ready, willing and able to provide its self-governing powers to manage an expanded health program.

I ask your permission to allow Mr. Koortbojian to testify on the technical aspects of our health care system and preliminary findings of our feasibility study.

Each of us would be happy to answer any questions you may have. Thank you, Mr. Chairman.

Senator McCAIN. Thank you.

[Prepared statement of Mr. Hostler appears in appendix.]

STATEMENT OF GEORGE KOORTBOJIAN, ST. JOSEPH HEALTH SYSTEM

Mr. KOORTBOJIAN. Mr. Chairman, I am George Koortbojian with St. Joseph Health System. We are working with the Hoopa Valley Tribe.

We are attempting to work with them to study the feasibility of implementing California's alternative rural hospital model.

That model was developed by legislation in California previously, and it looks to be a good opportunity for the tribe.

The feasibility study is designed to provide them objective data about making future decisions. That's really the important first step.

We are looking at the utilization data from the former hospital, as well as utilization data of the existing Indian Health Clinic.

In addition, we are looking at the costs associated with providing those services, and then, third, we are looking at what the community needs.

We are doing this through two means, a formal survey of the community, as well as public meetings with the community to obtain their direct input.

With the flexibility that would be afforded by the legislation you're considering, our preliminary results show that the alternative possible rural model could significantly improve the health care with only a marginal increase in the cost.

What we are really looking at is combining and expanding the existing clinic into some limited inpatient services and some skilled nursing services in the existing building.

Bear in mind, there is a building 200 feet away from the existing Indian Health Clinic, and that building is presently not in use.

We believe we can make good use of that facility with only a marginal increase in the cost. Mr. Biswell is going to describe briefly the California model.

[Prepared statement of Mr. Koortbojian appears in appendix.]

STATEMENT OF VIC BISWELL, ASSOCIATION OF CALIFORNIA HOSPITAL DISTRICTS

Mr. BISWELL. I am Vic Biswell, from the Association of California Hospital Districts. We are also helping the Hoopa Tribe in their efforts to reconstitute the health system in the Hoopa Valley.

I want to emphasize that today you now have available to you a number of alternative rural hospital models. Traditionally, you either had a hospital, or you did not, based on State licensing laws and Medicare conditions of participation.

Now there has been a lot of work done around the country to identify workable models that are essentially something less than a full service acute care hospital.

In California, we have identified such a model, and it does meet Medicare conditions of participation, which is very important, because if you're going to serve the non-Indian community, you certainly want to be able to tap on Medicare dollars.

Senator McCAIN. Thank you. Thank you very much all of you.

Senator McCAIN. Finally, the Honorable Allen Pinkham.

Welcome, Mr. Chairman. Thank you for coming back to see us.

STATEMENT OF HON. ALLEN V. PINKHAM, CHAIRMAN, NEZ PERCE EXECUTIVE COMMITTEE, LAPWAI, ID

Mr. PINKHAM. Thank you. My name is Allen Pinkham. I am the chairman of Nez Perce Tribal Executive Committee. I welcome the opportunity to be here.

I think we need to identify the needs of rural clinic areas. Our clinic has been deemed inadequate. In fact, Mr. Bill Pearson, the head of the IHS facility, has stated the present clinic has serious space deficiencies in all categories, and I am finding that is true.

it is an office building that needs to be redesigned completely, and we have pregnant women who are having to go down a stairwell for health care.

It is a depressing area. My people even stay away until their health becomes critical, and then they have to go to the hospital.

So it is very inadequate. it is also not on the priority list for larger facilities, but the Portland area office has nominated it, and we do have a map here to the left and rear of myself here to show you the areas of present constructions and proposed constructions, and there has been very minimal out in the northwest area.

So that is why we would like to very readily point out the deficiencies in construction as well, particularly rural area clinics.

Our proposal is for the Nez Perce Tribe to finance an IHS facility. We will design and construct it to IHS specifications.

We will finance it, but we also want the guarantee that IHS will come and negotiate a lease agreement with us. That would help pay off the debt.

But another thing that would probably be in the future is we need upgrading of equipment and new equipment and also adequate staffing for the new facility.

We do not want to construct a facility that is understaffed and under-equipped. I think the need has been pointed out by a report that has been issued on a study of our situation.

So I guess, in essence and in summary, we are going to take the initiative to finance the project, but we also want the guarantee and assurance that Congress will direct IHS to covenant a lease agreement and adequately staff and support funding the clinic.

In essence, Senator, that's our request at this time.

[Prepared statement of Mr. Pinkham appears in appendix.]

Senator McCAIN. Well, Mr. Pinkham, I think that is a very legitimate request on your part. If the tribe is ready to make a significant investment, it seems to me that you should have the assurance that the staff would be available.

So frankly, I think that would have to be part of any contract that we would enter into, and part of any legislation we might enact. I think you make a very legitimate point.

How much time, in the view of IHS will it take to complete the interim project that you spoke about in your testimony?

Mr. PINKHAM. Well, we have come up with some preliminary figures. Our space need is about 22,000 square feet, with an initial cost estimate of design and construction of about $3.1 million.

Senator McCAIN. When you get the new facility do you plan on making any major changes to the health services provided?

Mr. PINKHAM. Yes; I believe so. I think we need to consider, you know, it has already been determined that the patient load per doctor is very minimal at this time.

With a new facility that is designed to deliver health care, that load would be increased two to three times per doctor, so the benefits by far outweigh any other option that we have at this time.

Senator McCAIN. Without the facility, where would your tribal members go for treatment?

Mr. PINKHAM. Pardon, sir?

Senator McCAIN. Without this facility, where would they go for treatment?

Mr. PINKHAM. It would be contract health care. It would be to Lewistown, Idaho, which is about 12 miles away from the present clinic, but also we are a rural reservation, and travel goes to 70 or 80 miles away for other members that are not in the immediate community at the clinic level.

Senator McCAIN. Thank you.

Mr. Racette, I understand that your treatment center program, as I noted from your testimony, has a 70-percent success rate as far as alcohol rehabilitation is concerned.

It has recently been recognized by the IHS as one of the six best treatment programs in Indian country. Is that correct?

Mr. RACETTE. That is correct. They were not grading us on the facility at that time, just on the program.

Senator McCAIN. I think you can be very proud of that record, particularly in light of the condition of the facility in which you have had to operate.

In some ways, this facility particularly because it was condemned by State authorities, that it is a health risk for them to reside there. Is that correct?

Mr. RACETTE. That is kind of a phenomenon. Even though it is in a dilapidated condition, Indians would rather be with Indian people to deal with their problems, and I think that's the consensus of what you're hearing today.

That is something that I have asked Indian people that have completed non-Indian treatment centers, or had left early and were coming to us for services, is what is different about us, and basically they say, well, I do not feel alone here, and this is more of a family atmosphere. We feel that you care about us. We are not just another number.

Senator MCCAIN. When you get time, I know you are very busy, if you would submit for the benefit of this committee a more detailed description of the program that you have there. Most facilities do not enjoy your success rate, and I do not have to tell any of the witnesses here of the problems with alcohol abuse that exist in Indian country.

So we would be very interested in getting the details as to how you have achieved this success rate despite the conditions in which you have had to operate.

On a typical day, how many of the 20 beds in the New Day Treatment Center are filled?

Mr. RACETTE. Last year, we ran an 83-percent capacity. It typically runs between 83 to 85 percent. So, typically, 17 beds.

Senator MCCAIN. Thank you. Thank you very much, and, again, my congratulations on implementing an outstanding program, and I am sure that, from my visits to various facilities, its success rate is directly due to the kind of people that are involved, so you and the tribe are to be very highly commended.

Mr. RACETTE. Thank you.

Senator MCCAIN. Vice Chairman Hostler, I am very interested in your work with the concepts that are being implemented in nonrural areas of California, and I commend you on that, because, very frankly, that's a microcosm of what is taking place throughout this country now.

We are trying to find ways to get health care costs under control, and so I think it is very commendable what you are doing.

I understand, Mr. Vice Chairman, that there is a high rate of trauma in your area. Is that correct?

Mr. HOSTLER. Yes.

Senator MCCAIN. How long does it take to get a trauma victim to the nearest health facility?

Mr. MASTEN. From the center location of the reservation, we have to transport, as Mr. Hostler indicated earlier, over two mountain ranges.

The nearest hospital with trauma facilities is located 60 miles distance from us, which takes approximately 1½hours in good weather.

Part of the problem that is associated with that, of course, is bad weather in the winter time when there are times when the road is completely closed.

The other problem is that during the time that the ambulance has to transport patients this long distance they are out of the area for over 3 hours, which then complicates us maintaining coverage within the area.

So since closure of the hospital in June 1988, the local hospital, we have had to absorb extra costs in our ambulance program.

We do run the ambulance service for the entire area, and we have had to increase our costs by some $60,000 annually to hire additional staff so that we would have that coverage when the ambulance is out of the area for that length of time.

I would like to make one more point, that the primary industry in our area is logging, and we do have a lot of logging accidents, and, of course, in the mountainous area, a lot of automobile accidents.

Senator McCain. What is the extent of the diabetes problem?

Mr. Masten. We currently have about 320 patients who are infected with that disease that we monitor on a constant basis.

Senator McCain. That is 320 out of a tribal membership of how many?

Mr. Masten. In our service population, we have 3,800 Indian patients registered.

Senator McCain. So you are talking about close to 1 in 10?

Mr. Masten. Just about that, yes. A little less.

Senator McCain. That's an incredibly high incidence, and this, of course, puts a very big strain on your budget and your facilities.

Mr. Masten. Absolutely, and it also takes a lot of staff time to monitor these patients.

Senator McCain. Is the problem getting worse?

Mr. Masten. I think that we have it somewhat stabilized, because it is a program that we pay a lot of attention to. We continuously monitor our patients.

We have what we refer to as a diabetic exercise program, where we have an exercise session every day. We also tailor our meals.

Over at our senior center, the menus are tailored to provide the nutritional services that are compatible for individuals with diabetes, and then we have sent our field health people out into the homes to assist those individuals on what foods to buy.

In fact, we have had sessions where we have gone through the food shelves with the individuals and pointed out to them what is good for them and what is bad for them with their condition.

Senator McCain. Thank you very much, and thank all of you for being here today. If you would keep us apprised of the progress of your deliberations as you described to us in the various statements and when you reach some definitive conclusions as to how best you are going to address these issues, we would very much appreciate it if you would keep the committee informed.

Clearly, some of the solutions that you arrive at will apply to other tribes that at least geographically, similar circumstances.

Mr. Masten. We will certainly do that. One brief point, if I may. The work that we are currently doing on the feasibility study I think is right in line with what your thinking is, at least at this point, as we understand it.

But I think whatever conclusion we reach is going to require additional space, because, since the closure of the hospital, we are completely lacking with adequate space because of the patient load that has been transferred to us because of that closure.

When we get to the end of the feasibility, there is certainly going to have to be building construction or building renovation of the hospital that was vacated.

So that is going to be a concern, and as we view it now, there is no way that we are going to be able to come in on the IHS current construction priority list, so we are very interested in how this evolves through the process that you're going through now.

Senator McCAIN. Good. Thank you. I would like to repeat something that is very important here. We do not view any of these ideas as a way to reduce the IHS budget.

We will continue our efforts to increase the budget, both through the appropriations and budget process. We intend to be extremely active.

I know that Chairman Inouye shares my concern and view, so I hope that none of the witnesses nor the record would indicate that these proposals would diminish our efforts to increase the size of the health care budget.

I think the reality that faces us, both in non-Indian as well as Indian country, is when you have double-digit inflation associated with health care, we've got to explore every method that we can to provide the health care, and I would suggest that we have made written commitments to Native American tribes that we would fulfill that obligation, so therefore it seems to me we should explore every possible avenue.

The witnesses here and I am sure the next set of witnesses will provide us with, I hope, some ideas that we can pursue this year to try and catch up with what has been clearly a monumental task. Thank you very much.

Senator McCAIN. Our next panel will be Donovan Archambault, who is the chairman of the Fort Belknap Community Council; Dan Brown, chairman of the Leech Lake Reservation Business Committee; Russ Hawkins, chairman, Sisseton-Wahpeton Sioux Tribal Council, who will be joined by Steve Cournoyer, who is the chairman of the Yankton Sioux Tribe.

Before we begin with our witnesses, I would like to include in the record a statement by Senator Frank Murkowski, a member of this committee, for the record, concerning his interest and concern in this issue, without objection, and additionally included in the record will be a letter from the Alaskan Native Corporation that was written to the committee expressing their concern about the construction of the Alaskan Native Medical Center and their commitment to its construction.

Without objection, both documents will be made part of the record.

[Prepared statement of Senator Murkowski appears in appendix.]

[Letter from Alaskan Native Corporation appears in appendix.]

Senator McCAIN. Could we begin with Chairman Archambault? Mr. Chairman, are you ready? Welcome back.

STATEMENT OF DONOVAN ARCHAMBAULT, CHAIRMAN, FORT BELKNAP COMMUNITY COUNCIL, HARLEM, MT

Mr. Archambault. Yes, sir; thank you. I would like to express my appreciation on the part of you and the committee, Senator, for allowing us to sit here and hear our grievances and our problems.

I believe also that we can do some innovative things in health care delivery to Indians by working together and not taking an adversarial position, which has been the trend, I guess, within the Indian community since I have been chairman.

I believe that if we look at the need from a tribal perspective, we can look at a facility that is probably not a full fledged hospital; however, it is something more than a clinic, and it would deal with things that are alcohol and drug related, long term care for elders, acute care, naturally, and all of those things combined, instead of trying to do something in particular to acute health care.

We realize that the dollar constraints that exist, so in order to be able to make the dollar that we have stretch as far as possible, we need to integrate a lot of these concepts.

Those concepts exist in non-Indian communities, and I do not see why they cannot exist in Indian communities. I would like to see Indian health, with a little help from the Congress, go toward the community concept and include not only Indian tribes in these facilities, but the surrounding non-Indian community also.

I think that would alleviate the burden on the contract health care problem that we have at Fort Belknap right now. We are into the second quarter of next year in our contract health care, and it is a crisis thing because no one else gets care unless it is life or limb.

So with the ideas that we have and that we have discussed earlier, I believe that we can help meet the needs of our people.

I believe in order for this matter to be explored and tested, we have to establish some kind of a demonstration program, along with IHS, to really look at these health facility models that do exist in other communities.

We have to allow IHS to explore looking at long term care for our elderly at Fort Belknap. We have 25 people out in 7 different facilities in the State of Montana.

We would like to have those people at home. We have a population of over 250 people in the age bracket of 65 and over, so we are going to be looking at somewhere for those people to be placed.

We would like to place them on the reservation. I think in addition to that, we have a problem, in support of what we are requesting, I guess, the problem of travel, the environmental conditions, the severe winters we have in Montana, all those things lead to the kind of concept that we are talking about.

In the most recent meetings that we have had with IHS, I believe they are grasping onto the concept with a lot of positive input from them.

I think we have reached the point where we can work together and alleviate these problems. I believe financially it works elsewhere.

Health professionals like working in a newer facility or in a facility that has a wide range of services, rather than an old dilapidated hospital like exists on many of the reservations.

No one likes to work in those kind of conditions. It offers opportunity to hold the cost down through practices of itinerant surgeons coming in and doing the operations and then moving on to the next community, with followup care provided by the staff at the facility itself.

That would help us save some money. We have done a preliminary study, we have contracted with Jim May, who is pretty much an authority on rural health care.

We will use tribal dollars for him to do a preliminary study, I believe you have that, which we think will enable us to request the kind of money we have to have to do a real in-depth study that will show the justification for the kind of needs that we have.

We have the support in doing this from our tribal government, and I would like to again say that IHS is finally saying yes, I think you have a concept that we can work with and are willing to do that.

So I am just happy to be here and be able to pass to you the concerns that we have as a tribe and say finally for once that IHS and the tribes, I believe, are going to really address the problem of health care on the reservations.

Senator McCAIN. Thank you very much, Mr. Chairman. I appreciate very much your words, and I know that you have been faced with many frustrations over the years, and I am glad to see you are still willing to enter the fray in an atmosphere of cooperation and recognizing that these issues require all of us working together.

That does not mean we are not critical, when criticism is called for, of either the Congress or the executive branch. Thank you.

[Prepared statement of Mr. Archambault appears in appendix.]

Senator McCAIN. I would like to correct the record. The next witness will be Myron Ellis, who is a member of the tribal council of the Leech Lake Reservation.

Is that correct, Myron?

Mr. ELLIS. Yes; it is, Mr. Chairman. Mr. Dan Brown was not able to be here because of another commitment in another State.

Senator McCAIN. Thank you for being with us.

STATEMENT OF MYRON ELLIS, MEMBER, LEECH LAKE RESERVATION TRIBAL COUNCIL

Mr. ELLIS. Mr. Chairman, my name is Myron Ellis. I appreciate the opportunity to appear before this committee on behalf of the Leech Lake Reservation Business Committee to offer our views and recommendations on Indian health services.

I would like to commend Dr. Rhoades for putting the hold or the moratorium of closure of our hospitals. Hopefully, it will not be in a couple of years or so.

My formal statement is before the committee, and therefore I would just like to read a couple of our recommendations to this committee, if I may.

Senator McCAIN. Thank you, and your entire statement and the entire statement of all the witnesses will be made part of the record.

Mr. ELLIS. Thank you, Mr. Chairman.

First of all, we would like to recommend to enclose a statutory bar against IHS' closure of several hospitals identified by the GAO and Inspector General.

Mandate the IHS to undertake baseline health studies on the reservations where the above hospitals are located to determine appropriate curative and preventive services to meet the needs of the people; explore the feasibility of establishing joint use outpatient facilities for Indians and non-Indians where these opportunities exist.

Mandate the IHS to explore the feasibility of converting the hospitals identified for clos~~ure to~~ holding or temporary recovery care facilities with sufficient bed capacities to accommodate anticipated caseloads.

Authorize IHS to establish demonstration projects to accommodate joint use and holding facility concepts, establish such demonstration projects outside of the IHS' health facilities construction priority system.

Provide a separate authorization for appropriations and mandate the IHS to submit annual reports to the Congress on the progress achieved in establishing the demonstration projects.

Authorize tribes to participate in cost sharing with IHS for the construction of health facilities without jeopardizing the standing of less affluent tribes in the priority system.

Mandate the IHS to work with the tribes and coordinate its rural health care delivery systems implementation with Federal, State, county, private, and voluntary health care entities so that the experience gained may be utilized to improve the quality of health care, curative and preventive, for all of the Nation's rural citizens.

We are hopeful that our suggestions will assist you in drafting meaningful legislation to improve IHS rural health care delivery systems.

Mr. Chairman, this concludes my views and recommendations. I am prepared to respond to any questions you may have.

Senator McCAIN. Thank you very much, Mr. Ellis, and thank you for being with us.

[Prepared statement of Mr. Ellis appears in appendix.]

Senator McCAIN. Next we would like to hear from Russ Hawkins, who is the chairman of the Sisseton-Wahpeton Sioux Tribal Council.

Welcome back.

STATEMENT OF RUSS HAWKINS, CHAIRMAN, SISSETON-WAHPETON SIOUX TRIBAL COUNCIL, SISSETON, SD, ACCOMPANIED BY EVERETT BLACK THUNDER, ASSISTANT WAHPETON SIOUX TRIBAL PLANNER AND MANAGER

Mr. HAWKINS. Thank you. Mr. Chairman and members of the committee, I am happy to be here today. With me is Mr. Everett Black Thunder, assistant Wahpeton Sioux tribal planner and manager.

I am happy to hear the comments today, and I just want to briefly state that, as Indian people, we must never forget the treaties that we made, the concessions that we made, and the obligations that we as Indian leaders must constantly fight to see that they're upheld.

I would like to make just a comment that I, too, want to get along with other people, I want to get along with everybody here and all the respective tribes, but I also want to make it very clear what my purpose is at this hearing.

It is to talk about the frustration that the Sisseton-Wahpeton Sioux Tribe has had with Indian health service, to a degree with Congress, with the frustration that we've had for 20 years in getting a replacement facility in our rural area.

Our facility goes back to its construction dated 1936, and this is what my purpose is, to discuss that, to discuss our disenchantment with the system, with the priority system, and with the things that have transpired for the last 50 years.

I have submitted for the record over 30 pages of testimony, complete with statistics, with bar graphs, with charts, for those individuals who will read those.

However, I am going to make my presentation brief. I will highlight on it, and the things that I will say can be found in the submitted testimony.

First, I would like to briefly tell you just a little bit about the Aberdeen area, which I am from. As you know, there are 12 areas in the United States in Indian country, and we all have our needs.

We all have our needs in the area of health care, but within the area offices, there can only be one who is the worst in the term of infant mortality rate, there can only be one that has the shortest life expectancy.

Everybody cannot be the worst, only one can, and these statistics I obtained from Dr. Rhoades' staff administration in Rockville, MD.

I think the political as well as the lifestyle of a society can be determined in those two statistics. It is a pretty fair indication of the lifestyle that you're living when you look at your infant mortality rate and you look at your life expectancy.

The Aberdeen area has the highest infant mortality rate. Not the second highest, not the third highest, not one of the highest, the highest infant mortality rate.

The Aberdeen area has the shortest life expectancy. Not one of the shortest, the shortest life expectancy. In addition, we've got 5.7 times the diabetes rate and, of course, as we all know, diabetes leads to poor circulation, to amputation, to kidney failure, and to premature death, and that was the exact course my stepbrother followed at the age of 34 when we buried him two years ago.

You will recognize the fact that I was here last week. I appreciate that. Since then, we have buried three tribal members, whose funerals I missed, by the way.

So what I am saying is the Aberdeen area is in great need of facilities, and yet the new construction, the facility construction, has left out the Aberdeen area completely.

There isn't one facility in that new construction list that includes any tribe from the Aberdeen area. We've got one from Phoenix, one from Alaska, one from California, five from Oklahoma, four from Navajo, and zero from the Aberdeen area.

My concern is representing the Sisseton-Wahpeton Sioux Tribe and the people from that reservation. Our facility was built in 1936.

At that time, our population was 2,800 people. The staffing pattern in the 1936 construction was catered to 2,800 people.

Our latest enrollment has shown we are over 9,600 people. At 9,600 people, our staffing rate is not even filled to the 50 percent level that was developed in 1936.

IHS has funded approximately 25 percent of the need of our staff there. Even though it is outdated over 50 years, that aside, 50 years outdated, they still can't even come up with 100 percent funding for the staff.

We are using collections to pay 26 positions out of 52 positions. What that means is IHS is coming through with 25 percent of the staffing that's over 50 years old.

What is the result? Well, we can see some of the results with the statistics. I have a chart in there, I will not go through all those statistics, but you can be assured they are deplorable, they are alarming, and if these statistics were in any other society outside of Indians, the House and the Senate would be passing very big measures.

But because it seems to be Indian people, and because it seems that we do not rate as high for whatever reason, this has been a problem that's plagued us now for many years.

In 1977, Congress appropriated $400,000 for our architectural and engineering study for a new facility. However, in 1978, the Office of Management and Budget froze these funds.

A new formula was compiled, and it bumped Sisseton off the priority list that we had anticipated taking place in 1980.

As a result, the last decade has been one of frustration. We have had a temporary facility brought in for our patients. We have approximately 28,000 outpatient visits per year.

We have physicians leaving us at the rate, I think this past year we had 33 physicians leave us in a 12-month period. It is a revolving door with physicians.

The physicians are overworked, there's not enough money, Indian Health is not putting in enough money, and it is reflected in our mortality rate and our life expectancy.

These are the concerns of the people of the Sisseton-Wahpeton Tribe, and as their chairman, I do not want to compromise on any of our concerns.

I have a concluding remark, at which time I am going to ask Everett Black Thunder for his comments as our tribal health planner and manager.

The concluding remark I have is that I am requesting that the Sisseton-Wahpeton Indian Health Service Facility be grandfathered into the priority list.

There's clearly been an intent to have a new facility at Sisseton from both Congress and from IHS for the past two decades, over 20 years we are talking.

A great deal of time and money has already been expended, we came very close a year ago to getting this, but with the new formula, the new formula, incidentally, does not take into consideration the age of the facility, it does not take into consideration the infant mortality rate, does not take into consideration the isolation factor, does not take into consideration your staffing patterns, does not take into consideration your infant mortality rate.

The new formula that bumped us did not consider any of those things whatsoever, and as a result, we are out in the cold, we are hearing a lot of rhetoric, we are hearing how we have a government to government relationship, we hear about how we have obligations, but with all the rhetoric aside, we are still dying like flies, and we are still off the priority list.

So, Chairman, those are my concluding remarks. What I have said can be supported with documentation. There's no exaggeration here, and it has been submitted for the record.

I would like to take the remaining time for the Sisseton-Wahpeton Sioux Tribe to turn it over to our tribal manager and planner, Everett Black Thunder. Thank you.

Senator McCAIN. Please state your name for the record.

STATEMENT OF EVERETT BLACK THUNDER, TRIBAL MANAGER AND PLANNER, SISSETON-WAHPETON SIOUX TRIBE

Mr. Black Thunder. My name is Everett Black Thunder. At this time, I would like to address the opening statement that you the chairman had made in saying that whether or not there ought to be more flexibility in the type of health care facilities that are constructed.

I agree with that concept, but only if the Congress or IHS will deal with our tribe in that same aspect that Chairman Hawkins had mentioned in a government to government relationship.

We have a unique need and unique problems on our reservation. Sure, we can be covered under, you know, blanket terminologies from IHS.

They are calling us a tribe, and yet we have to have our needs and our problems fit into their formulas, fit into their processes.

When is IHS going to come and look at our tribe and develop formulas to fit our needs and our special problems?

That's one way in which I agree that there needs to be more flexibility based on that unique, one-to-one relationship.

The other thing is that I feel that in order for us to construct Indian health care facilities, that same concept has to be put into place.

All tribes are unique across the United States. All tribes have unique problems, unique situations, and yet we all have to fit into one blanket formula or blanket process.

I feel in addressing our unique needs, they need to approach us on a one-to-one basis, approach each individual tribe.

We as a small population tribe cannot integrate into their system based on high workload and high statistics that they need to facilitate their processes.

I thank you for making these comments.

Senator McCAIN. Thank you very much.

Senator McCAIN. Mr. Cournoyer, it is nice to see you. Thank you for coming, and I know you wanted to make some comments.

STATEMENT OF STEVEN COURNOYER, JR., CHAIRMAN, YANKTON SIOUX TRIBE, MARTY, SD

Mr. COURNOYER. Well, I'll make mine kind of short. Russell Hawkins, the chairman of Sisseton-Wahpeton, being from the same Aberdeen area, he has mentioned several statistics that also affect our tribe. You know, we are included within the Aberdeen area.

What I wanted to talk about is contract health care. I think contract health care has done some great things for our people out there, and it also has, you know, turned some things around where the statistics that are used when we talk about closures of some of these hospitals out on a reservation.

Our hospital, the Wagner Service Unit, has 23 beds, and we were in the proposed initiative from Dr. Rhoades that our hospital inpatient care would be closed, but I guess I missed the early part of the hearing when Dr. Rhoades said that there was a moratorium in place to stop the initiative of the closure on the hospitals.

But I think with the contract health care, what it has done is it has created some statistics that are misleading, you know, because one of the statistics that it shows on our reservation in the service unit was that there was only 8.5 or 8.7 births in 1987.

It does not show that there was 90-some referrals, you know, through contract health care, and the problem that it is creating now is that contract health care dollars are being used up by the first or second quarter, and some of these hospitals do not want to take our Indian people anymore because the money is not there to pay them, and they have got to wait 1 or 2 or 3 years or however long it takes, and it is creating a burden on our people that have very little resources.

When they go down there and they have to wait in line and then they've got to call back to the service unit to verify that they've been referred, and if they do not get paid within a certain amount of time, they start going after our Indian people, and sometimes their credit rating is ruined, they're harassed, you know, those kind of problems that I think some of these studies do not show.

So I think that contract health care has done some great things, but it is also, you know, misleading when it comes down to the statistics that show up in the studies.

I think what we are out there trying to do is we are out there trying to provide the best possible health care to our people.

It is very difficult to do that. You know, we were in line this coming year for construction of a new clinic at the Wagner Service Unit.

It is good that they were going to get that construction. You know, our hospital was built in 1935, just 1 year before assistance.

It was renovated in 1965, but our staffing at that hospital is based on the number of people they were serving from 1935 to 1965, and it is inadequate for our health care.

So our people out there in the Aberdeen area and the Wagner Service Unit are the ones that are suffering. I think the health problems have turned around in the last 30 years from tuberculosis to polio, and we are into an era where we are dealing with a high infant mortality rate, we are dealing with diabetes, we are getting into the cancers now, you know, those kind of health problems that we have.

It is costing a lot more money to deal with them, but we refer everybody out for contract health care, and we have very little money at the service units to deal with those kind of problems.

One of the problems that we also have is that our physicians, we would like to keep them there for 4 years, but a lot of times they stay 6 months, 8 months, 1 year, or 2 years, and then they leave.

If health services are going to improve, we need some way of keeping those physicians there, because our nursing staff, health technicians and whatever, they are there for a number of years, and that does not seem to affect the quality of health care one way or another.

What really affects it is retention of those physicians, you know, as our Indian people become more confident in physicians that are there and they start coming back and going there.

Otherwise, if they have title 19 or Medicare/Medicaid, they will go to the community hospital or one of the other hospitals or clinics in the area.

Those kind of things affect the statistics on the closure of our hospital, and I do not think that is what our people really want.

If it is going to be forced upon us, where do we turn from there? I do not think that contract health care is going to be the solution to the problems that we have out there.

Even with the new clinic that is going to be built out there, we are going to get the 10 exam rooms, we are going to get emergency, but if they leave out OB and some of those other services that our people really need, contract health care dollars dry up.

That is going to drastically affect the health care for our people out there. So those are my concerns. I think with the written testimony it will cover in detail a lot more of the problems that we are facing out there, and I think Russell has gone through some of the statistics that are showing that the Aberdeen area is at the bottom of the list when it comes to health care.

So with that, I thank you for the time, and if there are any questions, I will be happy to answer them.

Senator McCain. Thank you very much. Thank you for coming and sharing your views with us.

Chairman Archambault, I am interested in Mr. May's model. Could you tell the committee where this is currently in place?

Mr. Archambault. Some of the facilities that exist the model, I do not have a total list, but I know one facility in Wolf Point, MT, there are a couple in South Dakota.

I can get you a list, sir. We invited IHS to take a look at those models and maybe make the application at Fort Belknap.

Senator McCain. Thank you. You stated in your testimony that Mr. May concluded that were it a non-Indian rural community that facility would justify 40 or 50.

Do you have any idea how much this might cost to build?

Mr. Archambault. Well, I believe we feel that the money that has been appropriated to build the clinic at Hayes and the infirmary at Fort Belknap would be almost adequate to build the kind of facility that we are talking about.

I believe there may be a little more cost to it than what has been appropriated, but it would not be that much more. Again, I would like to stress, Senator, that we as a tribe are looking at a service that is needed, an unmet need out there.

I think the IHS in their studies, their RAM and RACK and all the nomenclatures they have to justify their existence or their needs, are strictly a money-saving device, and it is not looking at what tribal needs are.

To that extent, we invested some of our dollars to have Mr. May look at it, and it is really a superficial study that we thought would justify the need to go out and do a substantive investigation as to what is there, how we can fix it, and what it is going to cost us.

So I believe that we could build the kind of facility we are talking about with the amount of dollars that we have appropriated right now.

Senator McCain. I think that I share your view that model contributed quite a bit. I wish we had more of them.

Mr. Ellis, what has been the IHS justification for the closure proposal?

Mr. Ellis. Excuse me?

Senator McCain. I understand that the IHS had proposed to close your hospital.

Mr. Ellis. We are just one of the nine hospitals that are—

Senator McCain. What was their justification? Did they give you any justification for that?

Mr. Ellis. No; I am not familiar with a justification for closure of the hospital.

Senator McCain. I see. Are you currently treating any non-Indians in your facility?

Mr. Ellis. No.

Senator McCain. Would you consider doing so?

Mr. Ellis. Yes; we would. It was 1 year ago, when we were told that our hospital was going to close, we were meeting with the community of Cass Lake, the non-Indians and the Indian hospital.

We were proposing to put a clinic at Cass Lake to serve both non-Indian and Indian. However, the city of Cass Lake is now going in a different direction.

They are proposing to build a new clinic for non-Indians right in Cass Lake. However, our Indian people utilize that Cass Lake clinic, also.

Senator McCain. I see. Thank you.

Mr. Ellis. Do you need anymore data on outpatients?

Senator McCain. Maybe you could submit that for the record. We appreciate that information if it is not already in your statement.

[Information appears in appendix.]

Mr. Ellis. Thank you.

Senator McCain. Thank you.

Chairman Hawkins, I appreciate your frustration and your discontent. The reason why we are holding these hearings is to try and address the problem.

I agree with you that if a comparable health situation existed in non-Indian country, there would be funds forthcoming and the problem rectified.

I would expand on that slightly by saying that this also holds true for education. I do not know if you are aware, but a couple of weeks ago, about 3 weeks ago, I presented charts to this committee and on the floor of the Senate that clearly indicate in real dollars, since 1975, through both Democrat and Republican administrations, real Indian funding has continuously declined without any change.

Getting back to the issue of health care, I also am aware that it is the crisis within America, not only within Indian country but in non-Indian country because of the skyrocketing costs associated with it.

I cannot guarantee to you that there will be increased funding for health care or education or any other Indian program.

All I can guarantee to you is that there are a few of us who will continue to do everything we can to bring these issues to the attention of the Congress and to the American public.

I will continue to work in a variety of ways, including increased funding, but also in an attempt to find different ways to address these issues, such as some of the proposals that we have heard from some of the tribes today.

I believe that the tribes are better versed and more knowledgeable and better equipped to address some of these issues than people from Washington, DC. You have clearly stated the case that in Washington, DC there is not a clear understanding of the unique problems that exist, particularly from one tribe to another.

I could make a case to you that some Indian tribes, for a variety of reasons, are fairly well off. Clearly, you have made the case, convincingly, that your tribe is the worst off.

All I can tell you is that I will do everything I can to assist, and this committee will, I am sure, I know I speak for Chairman Inouye when I say this, but I also hope that you would be helping us in coming up with ways that are not always tied to dollars.

Although dollars are the integral part of it, there are also better ways of spending those dollars. So, again, I understand your frustration, and I appreciate it, and I can only say that I will do whatever I can.

I will be glad to hear your response to that comment, if you have any.

Mr. HAWKINS. Senator, I think that one of the things that we can see as a positive thing as Indian people and leaders, despite the deplorable statistics, we have the bright spot, the reason for optimism is for the few, the all too many few Senators and Congressmen such as yourself who are concerned, who are willing to give your time.

I notice you graciously acknowledged everybody's time they gave and certainly the time you have given to this hearing without a stopwatch running in front of you, letting the individuals testify, speaks very highly of your commitment to the Indian health issue in Indian country, and for that, Senator, I am grateful, and I thank you.

Senator McCAIN. I thank you for your kind words, Mr. Chairman, and I promise you I was not seeking a compliment when I said it, but I do appreciate your remarks.

Frankly, my job is to make other representatives aware, representatives who, if they were aware of the situation, would get more attention to these issues and more help for the bureaucracies.

By the way, I would also like to thank Dr. Rhoades and his staff for remaining throughout this hearing to listen to the testimony of all the witnesses. I appreciate that, Dr. Rhoades.

Steve, I share your concern about the closure and particularly appreciate having a copy of the report by the Native American Women Health Education Resource Center.

That will be very helpful to us. You can be assured it will be useful in the process of putting together a proposal to deal with the situation we are facing.

The record will be kept open for 30 days, and we will submit questions to IHS and HHS. To our friends from South Dakota, I will plan on a visit to come out and see you sometime hopefully when the weather is bad in Arizona and good in South Dakota, which might mean this summer.

I know that some of these things, for me to truly appreciate them, I need to pay you a visit, and I intend to do that.

Thank you very much. This hearing will now be concluded.

[Whereupon, at 11:57 a.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

STATEMENT OF
EVERETT R. RHOADES, M.D.
DIRECTOR
INDIAN HEALTH SERVICE

Mr. Chairman and Members of the Committee:

I am Dr. Everett Rhoades, Director of the Indian Health Service. I am accompanied by Mr. Bill Pearson, Associate Director of the Office of Environmental Health and Engineering, and Dr. John Porvaznik, Associate Director of the Office of Health Programs. I am pleased to be here to address those issues concerning the delivery and maintenance of comprehensive, high quality health care to Indian and non-Indian people in rural America.

Many difficulties confront this country in providing quality health care to the Nation's population. In particular, the unique circumstances affecting rural populations have reached a critical stage and require careful consideration of a variety of issues. These include the availability of routine care, levels of services which can feasibly be provided, and access to highly complex tertiary care. Rural populations are small, isolated and scattered. They frequently have additional problems such as poor transportation and high unemployment.

The difficulties faced by rural communities nation-wide are similar to those faced by the Indian Health Service (IHS) in its delivery of health care to Indian people. Because of the range and severity of the geographic conditions in some of these communities, IHS has encountered difficulties: in the recruitment and retention of qualified personnel; in balancing the demands for access while assuring high quality care; implementation of the most appropriate delivery system for a rural service area and in efforts to keep costs in control without affecting the level or quality of care provided.

I would like to discuss how IHS is addressing these barriers to health care and where our experience might be of benefit to both the Indian communities and their surrounding non-Indian neighbors in the development of innovative programs to meet their particular health needs.

The IHS is the largest most comprehensive rural health care delivery system in the United States. It provides a broad range of services to more than 1,000,000 Indian people. At present, Indian Health Service provides these services through 11 Area Offices which in turn direct the operation of 134 service units, 50 hospitals, 161 health centers and approximately 300 smaller health stations.

Preventive and therapeutic services are provided at all IHS and tribally-operated health care facilities. More specialized care is provided in three medical centers at Phoenix, Arizona; Gallup, New Mexico; and Anchorage, Alaska. Services that cannot be provided directly are purchased from the private sector utilizing contract health service funds.

Under the Indian Self-Determination and Education Assistance Act, Public Law (P.L.) 93-638, and its Amendments of 1988, many tribes are now contracting to administer their own health care activities. These range from directing such specific programs as the invaluable Community Health Representatives (CHRs) or Community Health Aids (CHAs), to the management of their own hospitals and service units.

The central role the tribes play is critical. The tribes now have a dominant role in structuring the health services delivery system desired by their communities. It is important to understand that in the design and implementation of any new and innovative health care delivery system, whether involving P.L. 93-638 or not, that involvement and acceptance by the affected tribe is essential.

Both tribal and IHS health care services encompass much more than the usual American concept of physician services rendered in a clinical setting. For example, health promotion and disease preventive activities are integrated with the usual clinical services. Also, construction of individual and community water and sanitation systems is a critical component of the Indian health system, as is an active public health program using educators, public health nurses and community health representatives (CHRs). Many other examples could be provided.

In order to meet the growing challenge of providing a broad range of quality health programs, especially during periods of severe budget restraint, the IHS continually reviews its overall capabilities and the resources available to the various Indian communities. The need for these efforts was reinforced by P.L. 94-437, The Indian Health Care Improvement Act, enacted in 1976 and most recently amended in 1988. This landmark legislation authorized new programs and additional resources to enhance IHS to fulfill its goal of "raising the health status of Indian people to the highest possible level", as well as to "encourage the maximum participation of Indians in the planning and management of those services." This mandate requires IHS to devise new and innovative means of providing health care to Indian people.

A key element in the IHS program is the construction of modern facilities in which to deliver ever more sophisticated care. IHS continually reviews its construction program to assure that the facilities are utilized to meet the most urgent health care needs for IHS funded programs in Indian communities. IHS does this through a formal facilities planning and approval process. This process prioritizes needs for construction, replacement, or renovation/expansion for both inpatient and outpatient facilities. In this process, the IHS reviews such factors as the workload, the condition of the existing health facility, and the accessibility of alternative sources of care. These alternative sources are evaluated on the quality of care, willingness to absorb Indian patients, and the cost-effectiveness of purchasing health care services from them. The facilities planning process is reevaluated regularly by our Headquarters staff, with input from Area staff and tribal groups, to determine where improvements can be made in the methodology.

The IHS planning process prioritizes the need for facilities through the application of established criteria and methodology for national comparison and ranking purposes. It is, therefore, not unusual that some tribes will fare better than others, based on their overall characteristics of health care need. As a result, some tribes do not have the opportunity to obtain new or upgraded facilities.

There are many reasons for this, but it most commonly results from the fact that the number of Indian residents is too small or their homes too sparsely located; or the clinical workload is too small to ensure quality medical care.

Additional problems confront tribes which take the initiative to construct or obtain facilities on their own. The IHS cannot, within our current policy provide funding for the staffing and operation of a new or expanded tribal health facility which was obtained using non-IHS funds. Nor do we support the construction or expansion of IHS facilities not on the construction priority list. We are presently studying whether some Indian communities, including new federally recognized tribes, may require special consideration.

When considering changes in delivery systems and tribal health administration, we believe there are several major elements that must be included:

- Continued Federal support and flexibility in strengthening tribal management.
- Clear identification of funding needs and sources.
- Positive community relations and enhancement effort.
- Accountability and strengthening of tribal financial capability.
- A clear definition of the risks and benefits of alternatives.
- Development of a means of continually evaluating and maintaining the quality of program service.

Any future innovative rural health initiative affecting Indian people should also focus on the following concepts:

- Maximization of all health care resources available to serve Indian people. This might include the use of IHS-tribal facilities by non-Indian patients for fee for service; and greater use of non-Indian facilities, such as local, private, State, Veterans Administration and military, to augment services to Indian patients.
- Development of a cost-sharing mechanism that would reduce the financial constraints affecting the provision of health care at a local rural community level. This might include joint-use agreements; designing multi-purpose programs that would permit a local Indian community utilizing non-Indian patient populations to provide services at a local level that could not be justified by the population of either individual populations.
- Exploration of the possibilities for new uses of under-utilized space. Such space could be used to provide services ranging from health education, preventative health care services, to short-term treatment of after-care services for specialized purposes.

- Enhancement of transportation systems to improve access.

In planning for any health delivery system, programs must maintain high quality and avoid duplicating existing programs. IHS supports the continued study of alternate methods to further fulfill the IHS mission of improving the health of Indian people. Once again, IHS emphasizes that tribal participation is mandatory in any new concept. I would like to reiterate that IHS's commitment to the important goals contained in both the Indian Health Care Improvement Act and the Indian Self-Determination Act will remain constant, regardless of the means devised to facilitate the provision of health care to Indian communities.

In summary, IHS is committed to seeking ways of improving services to Indian people and we would be extremely pleased to work with you, members of the committee, the tribes and health professional consultants to devise ways to address the pressing issue of rural health in America.

Mr. Chairman, this concludes my prepared remarks and I would be happy to respond to any questions you may have. Thank you.

PREPARED STATEMENT OF JEFF HUMAN

I would like to introduce a member of my staff Cathy Wasem R.N. Ms. Wasem formally directed a nurse training program on the Pine Ridge reservation in South Dakota.

It is a pleasure to be able to discuss with you this morning the innovative approaches being taken in non-Indian rural areas to address health care needs, particularly with respect to inpatient health care facilities.

Although these innovative approaches are in non-Indian rural areas, I believe much could also be learned by examining how the Indian Health Service (IHS) and the tribes provide integrated services. Not only does IHS manage a system of hospitals and health centers, it also provides a well-linked constellation of other social and health services--mental, environmental, public health, home health, and dental. Further, in many areas the IHS has developed regionalized systems of care for primary, secondary and tertiary services.

In addition the IHS, perhaps more than any other large provider of care, has made effective, efficient use of mid-level practitioners--nurse practitioners, nurse-midwives and physician assistants. The IHS has recognized these practitioners as providers of quality care when used in systems of care, and as providers more likely than others to continue serving Indian people. This is in part because many of these providers are themselves Indian.

An example of the ability of these providers to address health issues of critical importance to rural areas is illustrated by the situation on the Rosebud Reservation in South Dakota. When midwifery services were begun at Rosebud, the number of women receiving adequate prenatal care increased from 42 percent in 1983 to 82 percent in FY 1987, and the number of women receiving prenatal care during the first trimester also doubled. Additional accomplishments of the midwifery service include the integration of the maternity services provided at Rosebud into a regionalized perinatal system, and a reduction in the incidence of gonorrhea and chlamydia. Initial data also indicated a decline in the incidence of low-birth weight babies.

We in our office work closely with Dr. Rhoades and his staff. We are aware that they monitor carefully what is happening in the private sector that may work well in IHS as well.

I understand that the Committee is interested in the possible expansion of IHS facilities, including hospitals. I must tell you that most of the innovative approaches being taken in non-Indian areas involve downsizing or capacity limiting, developing greater efficiency, or monitoring the delivery approach.

There is a certain irony in looking to rural hospitals as models for success for Indian facilities. As you know, rural hospitals across the country are in trouble. Only about half of all non-Indian rural hospitals receive local tax support. These hospitals have been shown to be less likely to close than hospitals with no local support. Last year the report of the Senate Select Committee on Aging on this subject estimated that as many as 600 of around 2500 rural hospitals are in danger of closing. Hence "success stories" from rural hospitals often are stories of hospitals that simply hang on to the ledge instead of falling. The most frequent problem of rural hospitals is that the average daily occupancy in them is too low to generate sufficient operating revenues. This problem is exacerbated by a number of well known factors including low public and private payment levels, high levels of uncompensated care, and problems maintaining competitive compensation for staff.

To respond to these problems rural hospitals during the 1980's engaged in 5 general strategies:

- They converted inpatient capacity to other uses.
- They downsized their capacity and limited their services.
- They joined together into hospital systems.

- They used personnel innovatively.

- They undertook strategic planning initiatives and implemented service changes.

I would like to discuss each of these strategies briefly, beginning with the conversions of inpatient care capacity. Faced with declining admissions and declining length of stay, coupled with fixed facility costs, rural hospitals have attempted to convert excess hospital beds to other uses.

Perhaps the most popular program of conversion is one that Federal law has made possible. That is the swing bed program that allows rural hospitals to convert excess hospital beds to long-term care use and then if necessary, convert them back again to hospital use . This program emphasizes the flexibility we need to help rural health care institutions survive.

Some hospitals have simply converted their facilities or significant parts of them, on a permanent basis, to long-term care. Other general hospitals have converted to specialty hospitals, for example, substance abuse treatment facilities. A few hospitals have converted to primary care or emergency clinics. This is less common because the high fixed costs of hospital facilities often cannot be covered by these kinds of Services.

A second general strategy of rural hospitals has been to downsize their inpatient capacity, and increase their emphasis on outpatient care. It is difficult for governments, whether Federal or State to relate to these downsized facilities. Federal and State regulations presume a hospital to include a fixed and rigid set of services and personnel, which are not consistent with a downsized facility, which is less than a hospital but more than a clinic. You many be interested, Senator McCain, to know that until recently Arizona was the only State in the Union that had special flexible hospital licensure requirements for rural hospitals. For example, rural hospitals are not required to have surgical services. They also have less restrictive physician and nurse staffing requirements.

The first attempt to get Federal recognition and support for downsized rural hospital has been for the Medical Assistance Facility (MAF) proposal in Montana. The Department is supporting the development of this hybrid of a clinic and a hospital through a grant.

The MAF concept is advocated as a health care facility for communities that can no longer support a hospital, even a small one. The Montana MAF must be located in a county with less than 6 residents per square mile or in locations more than 35 miles from the nearest hospital.

Medical assistance facilities provide inpatient care until patients can be transferred to hospitals. And they are limited to providing 4 or fewer days care. The limit on the length of stay means that they treat only low-intensity or short-term acute care patients. They must also have emergency departments. MAFs can be staffed by mid level practitioners -- nurse practitioners and physician assistants under established protocols and periodic oversight by physicians--similar to the way rural health clinics are staffed. They can also be staffed by a combination of physicians and allied health personnel.

The facilities have to pass proposed State licensure and certification requirements that are a synthesis of Medicare hospital and rural health clinic standards. The modified licensure procedure assures quality services and, at the same time, reduces the regulatory burden for small facilities.

Colorado, Wyoming, Arkansas, and Florida's legislatures now have passed legislation establishing entities that are similar to MAFs. While we tend to think of MAFs as downsized hospitals it can work the other way as well. For example in Colorado, two of the five MAF type entities are "upsized" community health centers that previously provided only primary care but now have as many as 6 holding beds to use for patients who may stay for up to 3 days.

Last year's Omnibus Budget Reconciliation Act included authorization for rural primary care hospitals that are similar to MAFs.

California is about to take a somewhat different approach in a State sponsored demonstration that is based on a building block model. First a basic Alternative Rural Hospital (ARH) is defined with a minimum set of services. Next, additional services are allowed to be added where necessary. For example, emergency services are required but surgical services are an option.

In a few instances, communities have provided the impetus for rural hospitals to downsize and transform services. However, when this approach is taken problems with State licensure and Medicare certification may arise.

A third general strategy undertaken by rural hospitals has been to form hospital systems. These systems can either be composed exclusively of rural hospitals or they can anchored to urban tertiary hospitals.

Through economies of scale rural hospitals can reduce costs of equipment and supplies. When in systems of care they can share information systems and medical records systems. A full assortment of services can be provided through the system although individual hospitals may have limited services. They can offer continuing education programs.

When such systems are anchored to a tertiary hospital more specialized services can be provided to rural hospitals including outreach surgery, specialty clinics and telecommunications assistance in diagnosis and treatment.

The fourth general strategy is the use of innovative personnel systems. The patient load at rural hospitals often is so low that it is not practical to employ, for example, both a medical technician and a laboratory technician. So rural hospitals increasingly rely on cross-trained persons who are skilled in two or more technician fields. Administrative cross-training also is common. Thus a secretary may also double as a bookkeeper.

Use of mid-level personnel, such as nurse practitioners and physician assistants, is reducing the need for physicians in rural hospitals in many States where these professionals can assume considerable independence.

The fifth and last general approach rural hospitals use is strategic planning followed by implementation of plans.

The Federal Transition Grant Program administered by our Department has provided important impetus to strategic planning with grants to hospitals either to plan or to implement plans already made. Rural hospitals that have received grants have shown special interest in upgrading emergency services and recruiting health personnel.

New York operates a similar grant program with an emphasis on plans to diversify into new services and to form systems of care.

When communities and hospitals plan together, community needs can be explored and prioritized. Hospitals then can develop strategies to meet those needs.

Mr. Chairman this completes my survey of ways rural hospitals are responding to the needs of their communities to maximize the chances for their own survival and prosperity. I hope the Committee funds this information helpful.

TESTIMONY OF LORRAINE E. WHITE
PRESIDENT OF THE QUECHAN INDIAN TRIBE
BEFORE THE SENATE SELECT COMMITTEE ON INDIAN AFFAIRS
CONCERNING THE PROPOSED CLOSURE OF THE FORT YUMA INDIAN HOSPITAL

March 22, 1990
Washington, D.C.

Mr. Chairman, Honorable Members of the Senate Select Committee on Indian Affairs, Ladies and Gentlemen, my name is Lorraine White, I am the President of the Quechan Indian Tribe from the Fort Yuma Indian Reservation near Yuma, Arizona. I have the honor to address you today concerning a matter of great importance, the proposed closure of the Fort Yuma Indian Health Service Hospital.

The Quechan is very concerned and strongly opposes the proposed closure. We have many concerns, but they all may be summed up in one major point: regardless of the studies and projections made by the Indian Health Service administration, the proposed closure will result in lower quantity and quality health care for my people.

The foremost problem with the proposed closure is that it will change the way inpatient services being provided at the local in-patient facility at Fort Yuma, the Indian Health Service proposal will provide in-patient care at the Yuma Regional Hospital and will primarily be funded with contract health care dollars. Unfortunately, there is no way to guarantee that adequate funds will be available to provide inpatient services throughout an entire year. The Fort Yuma Indian Hospital has relatively fixed costs, and the marginal cost for each additional patient day of care is relatively slight. Under contract health care financing, the marginal cost of each additional patient or day of care is relatively high. All things being equal, ten patients per day at Yuma Regional Hospital will cost ten times as much as one patient per day at the Fort Yuma Indian Hospital.

Contract health care funds routinely run out before the end of each funding year. The result has been that contract health care services are available only as long as the funding lasts. For instance, in fiscal year 1989, the contract health care funds for the Phoenix Area were depleted by August 15, 1989. The Indian Health Service advised all service units to restrict their use of contract health care dollars to emergency situations only. Shifting funds to contract health care funding to increase the funding level will result in some in-patient services that are now available at the Fort Yuma Indian Hospital being made less available or even unavailable in order to conserve funds. This may result in little or no in-patient care being available near the end of the funding year. Either situation would result in serious negative consequences.

We are also concerned about the different admission and discharge standards which will be in effect at the Yuma Regional Hospital. The Yuma Regional Hospital utilizes a Diagnostic Related Grouping standard for admission and discharge. The diagnostic Related Grouping standard is less personal than the standard in use at the Fort Yuma Indian Hospital. The Yuma Regional Hospital is not oriented to either Indian culture or special Indian medical needs, and excludes factors which have been found to be important in determining admissions and length of stay at the Fort Yuma Indian Hospital.

There are two types of admissions practiced at the Fort Yuma Indian Hospital which are not included in the system in use at the Yuma Regional Hospital: the prevention-oriented admission system and the social admission system.

The prevention-oriented admission mainly occurs in diabetes related cases. I am sure this Committee is aware, Indian people in the Southwest suffer from diabetes at a much higher rate than the general population. Currently, when a person has diabetes-related wounds, instead of being sent home the person often is kept under supervision at the Fort Yuma Indian Hospital until any immediate danger of infection is over. Furthermore, people either recently diagnosed with diabetes or in need of further education often are allowed to stay at the hospital to learn and apply new eating and exercise habits while removed from their usual environments. This admission practice has helped prevent the advancement of the negative affects of the disease and people's conditions have improved.

The social admission occurs where a person's social circumstances either may aggravate a physical condition or may prevent that condition from subsiding. This can occur in a variety of circumstances, including cases where elders live along and need outside assistance, where pure drinking water is unavailable and where child abuse has occurred. In these cases, more drastic action and more expensive treatment often can be avoided by admitting the affected person to the Fort Yuma Indian Hospital and allowing for an extended stay.

These types of admissions and the extended stay policies found at the Fort Yuma Indian Hospital are an important part of health care services in our community, yet neither will be available at the Yuma Regional Hospital. Furthermore, the number of beds available at the Yuma Regional Hospital often are quite limited, especially during winter months when large numbers of elderly people visit the Yuma area. We feel this will only exacerbate the negative impact of the different admissions and length of stay policies at the Yuma Regional Hospital.

The Quechan Tribe is also concerned about certain cultural aspects pertaining to treatment at the Yuma Regional Hospital. When Quechan people are ill or dying and staying at the Fort Yuma Indian Hospital, family and friends are allowed relatively free access. This is very important for the patient, family and friends. This type or culturally significant accommodation would not be allowed at the Yuma Regional Hospital. The staff at the Yuma Regional Hospital are not as knowledgeable of and as sympathetic to the cultural differences of Indian people as are the staff at the Fort Yuma Indian Hospital. The doctors and nurses at the Yuma Regional Hospital are not as familiar as those at the Fort Yuma Indian Hospital with medical conditions which are prevalent among Indian people but relatively rare in the general population, such as adult-onset diabetes.

Another major problem with the proposed closure is lack of transportation. The Fort Yuma Indian Hospital is located on our reservation, but the Yuma Regional Hospital is located approximately 15 miles away. Currently many people can walk to the Indian Hospital, but will not be able to walk to the Yuma Regional Hospital. The Community Health Resources personnel provide transportation to the Fort Yuma Indian Hospital when needed, but current regulations will prevent them from transporting people to the Yuma Regional Hospital.

There is one final consideration which has been overlooked by the Indian Health Service administration, that is how the Quechan people feel. The Fort Yuma Indian Hospital has been on our reservation for nearly 60 years. The Quechan people have grown up with the hospital, they depend on it, it has become an important part of the community. The policy of the United States government is to promote self-determination for Indian people, and to heal the wounds Indian people have suffered as a result of past bureaucratic insensitivity. The closure of the Fort Yuma Indian Hospital against the Quechan Tribe's wishes will help to achieve neither of these things.

Lastly, today the Committee is holding this hearing to consider the development of legislation to include expanding the Indian Health Service definition of a health care facility to include alternative health care systems. I hope that the testimony that I have presented will assist you in recognizing that alternative systems are necessary and needed in Indian communities.

Thank you for providing me the opportunity to address you today. I will be glad to answer any questions you may have.

Lorraine E. White

Lorraine E. White, President
Quechan Tribal Council

TESTIMONY OF

BERNARD BOUSCHOR

TRIBAL CHAIRMAN

SAULT STE. MARIE TRIBE OF CHIPPEWA INDIANS

Mr. Chairman, members of the Committee:

My name is Bernard Bouschor, and I am Chairman of the Sault Ste. Marie Tribe of Chippewa Indians, an Indian tribe located in the eastern portion of Michigan's Upper Peninsula. On behalf of the Tribe, I want to thank you for extending to us this opportunity to appear before you to discuss issues related to rural health care facilities in Indian Country. In doing so we will focus on our need for facility construction and how that need is not served by the present priority system.

The Sault Ste. Marie Tribe has a reservation and several trust land areas in the eastern half of Michigan's Upper Peninsula. The Tribe's reservation is located in Sault Ste. Marie. There are also communities located on trust lands in St. Ignace, Hessel, Manistique and Munising. The trust land sites are located from 50 to 130 miles from the Tribe's reservation and seat of government in Sault Ste. Marie. The Tribe operates Indian housing on all of these sites.

With regard to health care, the Indian Health Service recognizes the seven eastern counties of the Upper Peninsula of Michigan as the Tribe's service area. The membership population within this seven county area is 8,500. The tribal health program currently operates on a budget from IHS of $3.1 million per year. With this funding it serves 7,000 members annually in some way or another.

The Tribe has special needs for health facility construction which have their origin in the unique organizational history of the Tribe. The Tribe was not federally recognized until 1973. Recognition was achieved before the federal government had developed a process for recognizing and budgeting for previously unrecognized tribes. As a result, recognition did not result in any systematic approach to funding tribal needs, and it was a constant struggle with BIA and IHS to achieve funding for programs which were taken as a matter of course by established tribes.

The Tribe has endeavored to overcome these obstacles in order to meet the health care needs of its members. In 1978 IHS took advantage of the closure of Kincheloe Air Force Base, located 25 miles from Sault Ste. Marie, to lease the former air base hospital for $1 per year as its outpatient facility for the delivery of health care services. IHS operated outpatient and community health services from the site until September 28, 1988, when the Tribe took over health care from IHS under P.L. 93-638.

The facility is inadequate and poorly located for service delivery. The Tribe is sorely in need of a new facility.

The current IHS system for prioritizing IHS facilities construction does not even begin to adequately address the Tribe's need for a new facility, nor does it take into account the Tribe's unique history. The amount devoted to this activity by IHS is not even sufficient to keep abreast of the depreciation of existing facilities, let alone the construction of new facilities. The backlog of over $500 million in proposed facilities already in the system is enormous. To compound the problem, our needs have not yet even entered the priority system pipeline, and it is estimated by IHS that it would be a minimum of 20 years before we would come up on the current priority system. That means that under the existing system at least one generation of tribal members will be inadequately served or not served at all before the IHS priority system will meet their needs.

The Kincheloe location, which may have been ideal for an Air Force base because of its isolation, is a major barrier to accessing health care for tribal members. The Tribe's major population center is Sault Ste. Marie, which is 25 miles from the facility. There is no tribal or other public transportation system to provide access to the facility. The location and design of the facility, which was a full hospital when used by the Air Force, prevent us from providing the quality and quantity of services normally provided at the average IHS-funded facility.

In December 1986 IHS hired a consultant team to prepare a master plan for the Kincheloe facility. The consultants recommended that the outpatient care services be relocated to Sault Ste. Marie, for the following reasons:

1) To locate the facility should be nearer the critical mass of tribal population -- the 3500 or so members in Sault Ste. Marie. This is by far the largest concentration of membership in the Tribe's service area.

2) To increase accessibility, and hence service, to

the majority of patients served. The members in Sault Ste. Marie currently account for only 43% of patient contact visits today. That is projected to increase to almost 75% -- an over 50% increase -- if the services were relocated.

3) To allow location of other related tribal health and social services programs in the same facility, thereby increasing service coordination and reducing overall cost.

The projected increase in usage with a move of the facility to Sault Ste. Marie is a direct measure of the barriers to health care created by the present remote location of the facility. This unmet need is a compelling argument for the new facility. The existing facility is also obsolete and carries with it a high maintenance cost which would be reduced with a new facility.

Since taking over the operation of the facility, the Tribe has contracted for a planning and preliminary design study for a new tribal health and social services building to be located in Sault Ste. Marie. Preliminary design requirements based on IHS methodology indicate a need for a building with a gross area of 70,000 sq. ft. at a projected cost of at least $8.5 million.

At present the Tribe has only a Hobson's choice between two equally impracticable alternatives:

1) wait in line under the current IHS priority system, and watch a generation of members go without adequate health care; or

2) attempt to finance the project on our own, thereby decreasing the money available to provide health care services and other essential services to members.

We believe that an innovative approach makes sense from a national policy perspective and would allow the Tribe to escape the dilemma. If IHS were given the flexibility to depart from the rigidity of the current system to engage in cost sharing on facilities, we could build our facility, and the federal government would save money in the long run. The Tribe is prepared to finance a portion of the cost of construction if the construction costs were shared 50-50 by the Tribe and IHS. The Tribe would finance its portion of the construction through tax exempt bonds under the Indian Tribal Government Tax Status Act.

Given the desperate need for facilities and the budget constraints at the federal level, this Tribe is willing to shoulder an equal share of the construction cost in order to meet the needs of its members. The current priority system does not allow for this option and inhibits such innovative approaches. Alteration of this policy to allow the joint venture described would be good fiscal policy and would allow the Tribe to meet its members' health care needs in this generation, rather than the next.

P.O. Box 219 Owyhee, Nevada 89832-0219 (702) 757-3161

IN CONTRIBUTION TO THE HEARING BEFORE
THE SENATE SELECT COMMITTEE ON
INDIAN AFFAIRS - MARCH 22, 1990

REGARDING INDIAN HEALTH SERVICE
FACILITIES IN RURAL INDIAN COUNTRY AND
PROPOSED LEGISLATION PERTAINING

From; James Paiva
Tribal Chairman
Shoshone-Paiute Tribes of Duck Valley

It is an honor and a privilege to be before you today. We at Duck Valley have long been struggling to fully utilize our hospital but nave been hampered by Indian Health Service restrictions and definitions. We have a beautiful 4 million dollar hospital which was completed in 1976. It contains a fully equipped 15 bed inpatient capability, outpatient clinic, X-Ray, laboratory, minor operating room, OB ward, dental, pharmacy, emergency room, administrative offices and related facilities. IHS has also numerous apartment complexes located near the facility for service personnel.

The Duck Valley Indian Reservation is located in what has been termed as the West's forgotten corner. A remote area 100 miles from Elko, Nevada to the south and 100 miles from Mountain Home, Idaho to the North. Our hospital has been invaluable to the life and limb of the Indian and the non-Indian of this remote region. We have a public school on the reservation which is attended by over 400 students. Our Reservation is the hub of the adjacent ranches and mines for community health and other services.

The Phoenix Area Office of the Indian Health Service had slated our Community Health Hospital for closure without, what we view as, the proper considerations. Their rationalization overlooked several important factors and was without merit in our view. Their tunnel vision and fiscal needs elsewhere dictated to them the closure of our inpatient and 24 hour emergency care along with the relocation of professional service people. We called upon with success for the intervention by our congressional representatives for a stay of the closure until we were satisfied that we were not being railroaded as a sacrificial lamb and that our needs were properly addressed. We are now and have been seeking an innovative approach which will fully utilize the hospital for the Indian and the non-Indian of the region. We would like to go beyond IHS definitions and constraints for an effective health care delivery plan and perhaps long term rehabilitation, convalescence and specific therapy treatments.

Of the 15 beds available at Duck Valley, 12 are designated for adult, 2 for pediatric and one for infant usage. IHS requires extensive paper work should a "bed" not be utilized for it's designated purpose. Perhaps a "swing bed" (changing definition of bed usage) could be implemented through this demonstration program.

We would like to hereby request that the Shoshone-Paiute Tribes of Duck Valley become a part of this five year demonstration project to present an alternative to the current IHS definition of a rural health care facility. Presently we are seeking funding through IHS and perhaps by the proposed legislation to conduct the Full Utilization Study. We feel that we would be able, within the five year demonstration period of the proposed legislation of Senator McCain, to determine the most cost-effective means as well as enhanced health care delivery. Such as now a non-Indian visit to the outpatient clinic costs at a minimum $76.00 per visit by IHS standards, we feel would be able to cut that cost to the user. A CPT (Cost per Treatment) rate would be substantially less and more attractive competitively. New money from enhanced third party service delivery would be the result of an innovative scenario. We would not be looking to discredit the Indian Health Service but would be seeking to enhance it with our Tribal Government's involvement. The Tribes of Duck Valley would be working with the Indian Health Service rather than in the adversary role we have been associated with in the past.

Our specific request to become a part of this demonstration project does not involve facilities construction funds but rather an innovative approach to fully utilize our rural health care facility for the Indian and the non-Indian of this remote region.

Thank you very much again for the opportunity to be before your distinguished committee. I will be happy to answer any questions.

MAR 16 '90 10:49 DHHS PHS/PAIHS

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Phoenix Area Indian Health Service
3738 N. 16th St. Suite A
Phoenix, Arizona 85016-5981

March 16, 1990

The Honorable James Paiva, Tribal Chairman
Duck Valley Shoshone Paiute Tribe
Duck Valley Indian Reservation
P.O. Box 219
Owyhee, Nevada 89832

Dear Chairman Paiva:

The Phoenix Area staff appreciated the opportunity to meet with you and Lindsey Manning, Tribal Planner, on March 15, 1990 concerning the Owyhee Service Unit Hospital.

The documents presented relative to a full utilization study for that facility, especially regarding non-conventional methodology, seem to offer promise. The Phoenix Area Indian Health Service supports the Tribe's efforts towards planning for full utilization of the Owyhee Hospital, however, we currently do not have funds to assist in implementation.

The Office of Indian Community Resources, Office of Program Planning, and Area Contracting will be available to assist the Tribe in review and completing the necessary documentation for planning for such full health utilization of the Owyhee Community Health Facility, should funding become available.

Your interest in the health care delivery system and your efforts to improve services are appreciated.

Sincerely,

Mary Lu Stanton

for Don J. Davis, M.P.H.
Director, Phoenix Area Indian
Health Service

PREPARED STATEMENT OF

MR. PAT RACETTE, DIRECTOR, NEW DAY TREATMENT CENTER

AND

MR. CHARLES LOONSFOOT, TRIBAL COUNCIL MEMBER

KEWEENAW BAY INDIAN COMMUNITY
L'ANSE INDIAN RESERVATION
BARAGA, MICHIGAN

BEFORE THE SENATE SELECT COMMITTEE ON INDIAN AFFAIRS

OVERSIGHT HEARING ON IHS FACILITIES

March 22, 1990

INTRODUCTION

Mr. Chairman and members of the Committee, thank you for the opportunity to provide testimony on the concerns of the Keweenaw Bay Indian Community about Indian Health Service Facilities. My name is Pat Racette, Director of the New Day Treatment Center and accompanying me is Charles Loonsfoot, Tribal Council Member.

On behalf of the Keweenaw Bay Indian Community, we would like to thank the Committee for scheduling this hearing to investigate the problems associated with the construction of IHS and tribal health care facilities. The Keweenaw Bay Tribe has been struggling since 1986 to build a new health facility to replace our current building which has been condemned. Although the Tribe has generated $1.4 million on its own initiative for construction, we are unable to receive any federal assistance under current law and the existing IHS Facilities Priority System. We are hopeful that this hearing will document the need for alternative approaches to the construction of tribal and IHS health care facilities. Unless something is done to assist Tribes such as Keweenaw Bay, it is doubtful that we will ever solve our health care facility crises.

BACKGROUND ON THE KEWEENAW BAY TRIBE

Our community consists of approximately 3,200 enrolled members and our Reservation land base is 55,000 acres situated on the shores of Lake Superior's Keweenaw Bay. The Reservation is divided into two major communities, L'Anse and Baraga, located on opposite sides of Keweenaw Bay. The Reservation is unique in that the tribal membership is outnumbered by non-Indians who comprise 85% of the Reservation population. We are fortunate, however, to have a cooperative working relationship with the local non-Indian hospital for outpatient care and as a matter of fact, the Tribal Council Vice-Chairman, Mr. Wayne Swartz is also the Chairman of the Baraga County Memorial Hospital Board of Directors. In the planning for a new tribal facility, we are looking at close coordination with the Baraga County Memorial Hospital to enhance coordination of services for tribal members, particularly contract health care.

NEW DAY TREATMENT CENTER

The Keweenaw Bay Tribe owns and operates the New Day Treatment Center, a residential alcoholism rehabilitation program supported by IHS and State funds, which has been in existence since 1974. The Center is also licensed by the State of Michigan. Its primary purpose is to provide alcoholism rehabilitation services to the Michigan American Indian population, but services are also provided to Indians from the States of Wisconsin, Minnesota, Illinois, and other states. The Center has 20 beds and is staffed by 16 professional alcoholism treatment personnel and support staff. Since October 1974, 1,652 clients from throughout the Bemidji Area of the Indian Health Service have been served. The New Day Treatment Center provided treatment to adolescents from 1974 to 1985 but stopped at the request of the Tribal Council until such time as a facility can be built that will ensure the personal safety of adolescents and treatment in a separate environment from adults which is required by state and federal law.

The success rate for rehabilitated clients has been 70%, based on the medical records and follow up services. In 1983, the Indian Health Service cited the New Day Treatment Center as one of the nation's top six centers based on an evaluation of 200 Indian Health Service Tribal treatment centers nationwide.

TRIBAL HEALTH OUTPATIENT CLINIC

The service population of the tribal health services is a priority population, because of being socially isolated, culturally traditional, economically disadvantaged and characterized by significantly unique health and mental health needs. In 1973, the Keweenaw Bay Indian Community Tribal Health Service was created as a prototype for other rural reservation health centers in the Bemidji Area of IHS. The steady growth of the program components, including mental health services, has been directed toward the goal of the provision of community and family based, culturally sensitive services and treatment.

The Tribal Health Services Program provides a broad range of preventative and acute care services with 4,100 primary care visits annually and 10,000 patient contacts through other program components. The primary components include:

1. Medical Clinic: In operation since 1973 which offers physician coverage 3-4 days per week for an average of 5,000 patient visits per year. The medical staff also provides services to the New Day Treatment Center.

2. Dental Clinic: Services are provided by a dentist, a part-time dental hygienist, dental assistant and receptionist. Dental visits average 1,600 per year.

3. Community Outreach: Services are provided by a Community Health Nurse and two Community Health Representatives who coordinate with the Michigan Department of Social Services to link eligible clients with State services and assistance.

4. Mental Health: Provides a psychologist two days per week, a full time clinical social worker, and a full-time victims of crime assistance coordinator.

5. Nutrition: Professional consultation and community health education are provided by a full time registered dietitian and a nutrition education technician who provide services to three Tribes in the area. Keweenaw Bay contracts with the Michigan Department of Public Health for operation of a local WIC Agency, and serves the largest Indian caseload in the State. Service are also provided to the Hannahville and Lac Vieux Desert Tribes.

6. Adolescent Health: Services provided under the coordination of the Health Educator include the "Say No Program", a teen-based and teen-presented program of self-esteem and personal choice decision making presented to grades 7-12. Coordination with nutrition services in an ongoing program is focused on eating disorders prevention among American Indian teenage females. Along with the Community Outreach Services, a community developed and community based teen pregnancy and teen parenting program is operational.

SUMMARY OF THE KEWEENAW CLINIC FACILITIES PROBLEM

Both the New Day Treatment Center and the Tribal Health Services, as well as almost all programs and administrative offices, are located in the Keweenaw Bay Tribal Center in Baraga. This building was constructed in 1928 as an orphanage operated by the Catholic Church and donated to the Tribe in 1970. Although historically significant, the building was never intended to be a medical or alcohol treatment facility, but there are no alternative health care facilities available on the Reservation.

Several physical plant inspections have been conducted over the past several years by various governmental agencies which are as follows: Structural Survey, PHS, Chief Sanitarian 1987; Fire Safety Inspection Report, Michigan State Police Fire Marshall Division, 1979, and the IHS inspects yearly and has noted these deficiencies; Environmental Health Survey Report, PHS, 1985. These inspections cited numerous health, safety and regulatory violations. The following is a list of only the major defects:

Lack of adequate fire exits, adequate ventilation, temperature control, handicapped accessibility, automatic sprinkler system, and fire doors; extensive use of combustible building materials; lack of electrical system inspection; need to separate the heating plant from the building; and serious space shortages for alcohol treatment living quarters and health care delivery. Approximately 50 different areas of concerns were noted in this inspection reports, but only those areas posing a high degree of danger were addressed due to lack of funds. An evaluation report of the clinic and treatment center conducted by IHS headquarters staff in 1987 characterizes the facilities as follows:

"It is plagued by serious mechnical and physical deficiencies.... Among the more serious problems are limited egress in case of fire, no hot water in the clinic, space is very inadequate, water supply is limited, water leakage is widely evident, sewer system is unreliable, heat is not dependable (wood is used) and not easily regulated, the fire doors do not operate properly, when it rains the elevator shaft floods and the elevator does not work, etc., etc."

In the last ten years, over $173,000 of Tribal and grant funds have been spent just for essential repairs to the building.

Based on the inspection, the Michigan State Fire Marshall found the building out of compliance with applicable rules and recommended that the building be condemned and vacated due to safety hazards. However, the State does not have the jurisdictional authority to condemn Tribal facilities on trust lands. Because there are no alternative facilities, the Tribe has been forced to continue operations in the current facility.

Both the New Day Treatment Center and the Tribal Health Services Program have been warned that if the facilities are not improved to the point where they can be accredited by the Joint Commission on Accreditation of Hospitals (JCAH), that IHS and the State could discontinue providing operating funds. This would completely eliminate the New Day Treatment Center and would eliminate the majority of the health services. The Medical and Dental programs would have to be terminated and replaced with contract health care services which have proven to be far more expensive than direct care.

Even with its deficiencies there is a large backlog of people seeking treatment whom we are unable to provide services due to lack of space and funds. Additionally we are currently unable to provide any residential treatment for our adolescent population. Many more people are reluctant to seek treatment at a facility located on the top floor of a building which also houses almost all of the tribal program and administrative offices.

Ninety percent (90%) of the residents coming into the Treatment Center are referred through the court system for alcohol related offenses. Of this number, 19.9% are unable to pay for services which results in a loss of revenue for the Center. The facility cannot qualify for medical reimbursement for these and other clients because of physical plant deficiencies. The Tribe continues to accept clients despite their inability to pay, however, third party payment would be available if the building met accreditation standards.

SUMMARY OF TRIBAL EFFORTS TO REPLACE CLINIC

Providing adequate health care to tribal members and continuing operation of the New Day Treatment Center is one the highest priorities of the Tribal Council. Accordingly, in 1985, the Tribe commissioned the firm of Graheck, Bell, Kline and Brown to determine the costs to renovate the Tribal Center in order for both programs to meet JCAH accreditation standards. According to the engineering estimates, renovation costs are $2,233,130 (1986 figures). This is almost the amount of new construction. The Tribe decided against renovation because the facility is 60 years old and could be subject to major structural problems at any time.

Two years ago the Council directed tribal staff to begin raising the necessary funds to construct a new tribal health facility and treatment center. The design which has been completed at Tribal expense would accommodate both an outpatient clinic and new facilities for the New Day Alcohol Treatment Center at a cost of approximately $3 million.

By 1988, the Tribe had generated $1.4 million for construction from a combination of non-federal funds (tribal, state, loan and grants). We are fortunate to have the support of Senator Jacobetti, Chairman of the State House Appropriations Committee, who is from our district and willing to support a $500,000 state appropriation to match federal and other funds which we raise. Funding sources that were secured included: The Keweenaw Bay Tribe ($200,000); HUD Community Development Block Grant ($250,000); Kresge Foundation ($500,000); IHS water and sewer ($35,000); State of Michigan Office of Substance Abuse ($100,000); and State of Michigan Appropriations Committee ($500,000).

Also in 1987 and 1988, we requested to be placed on the Indian Health Service Facilities List to receive federal funds for the construction of a new facility. We were hopeful that our matching funds would enable the tribal application to be favorably considered. However, under the current priority system, Keweenaw Bay would not rate high enough on the list to be eligible for consideration for many years. The current IHS Facilities Priority List does not work for Keweenaw Bay for the following reasons:

1. Primary Care Provider Visits Criteria: The existing priority system is numbers driven according to the number of primary care provider visits. In 1987, the baseline year for the Priority List, the Keweenaw Bay Tribe was without a doctor and dentist for six months. Consequently, the number of visits at Keweenaw Bay numbered 4,000 - too low to be considered a high work load area -a key factor in the Priority List. In 1988,

however, when the clinic was fully staffed, the number of Primary Care visits was over 10,000. This number, however, would still not elevate the Tribe high enough to be considered for many years. We feel that the Priority List works to the disadvantage of Tribes like Keweenaw Bay which have relatively small and rurally isolated service populations. Even though the numbers for small tribes may not be as great, the need for health care is just as legitimate.

2. Condemnation of the Facility: The IHS failed to incorporate the structural deficiencies and condemnation of the building in its evaluation for construction priority ranking.

3. Lack of an Architectural Survey: The IHS did not conduct a "deep look" architectural survey to assess the basic structural condition of the facility.

In FY 89, we approached the Congressional Appropriations Committees and Congress to request a 50% federal match for the funds the Tribe raised for construction of the Clinic, only to find that under current law there is no provision for cost sharing on the construction of tribal health facilities. We understand that the existing Priority List serves a useful function to assist Congress in objectively directing the extremely limited construction funds to those facilities determined to be in most critical need. Given the estimated $700 million dollar backlog in IHS Facilities construction, we doubt that Keweenaw Bay will ever rank high enough to be earmarked for construction funds under the present priority list. This year, as an example, IHS failed to request funds for any new outpatient clinics.

We understand the concerns of the Appropriations Committees about any increased staffing and operational costs incurred as a result of the construction of Indian health facilities other than those provided for under the IHS Facilities Priority List. In the Keweenaw Bay situation, however, our proposed facility would not significantly increase staffing because both the clinic and treatment center are adequately staffed. In addition, the income from third party payments which could be generated from an accredited facility could be used to offset any staffing increases which might be incurred. On the other hand, we would not want to be precluded from any periodic staff increases which would be provided overall for the operation of tribal clinics and facilities. A new facility would result in considerable savings in operation and maintenance costs because of increased efficiency in heating, cooling, and other areas. Considerable savings would be realized in facilities improvement and repair which are currently very high due to the dilapidated condition of the existing facility.

TRIBAL RECOMMENDATIONS FOR CONGRESSIONAL SUPPORT

In light of the barriers which the Keweenaw Bay Tribe and others have encountered under existing law pertaining to the construction of IHS Facilities with non IHS funds, we strongly urge that Congress enact new legislation to authorize Tribes to puruse a cost sharing approach to the construction of IHS and tribal health care facilities.

We recommend that this approach be tested on a pilot project basis for those Tribes which elect to exercise the option of cost sharing. Authorizing a limited number of facilities under a second priority system would enable Congress to evaluate the relative costs and benefits associated with a cost sharing basis. It would be absolutely critical, however, to authorize and appropriate additional facilities construction funds for this purpose, as we would not want to detract from the progress under the existing Facilities Priority list.

We also understand that some Tribes may have concerns about the tribal financing of health care facilities as an erosion of the Indian Health Service trust responsibility and obligation to provide facilities for the delivery of health care. If the Committee were to develop legislation authorizing cost share of construction funds, it must be emphasized that this is not meant to replace or diminish the federal governments responsibility for those Tribes that do not have the resources to raise funds for facilities construction.

We also recommend that an alternative Priority List evaluate the need for facilities as well as any innovative health care delivery systems which would be provided by Tribes.

SUMMARY

Mr. Chairman and members of the Committee, thank you for the opportunity to testify on the problems associated with IHS Facilities. We appreciate your concern and interest in this problem. We urge the Committee to develop legislation to assist Keweenaw Bay and Tribes in similar situations to develop a workable solution to meet our health care needs and stand ready to work with you to resolve these problems.

HOUSE OF REPRESENTATIVES
LANSING, MICHIGAN
[illegible]

D. J. JACOBETTI

June 23, 1987

Mr. Theodore Holappa, Administrator
Tribal Health Services
Keweenaw Bay Tribal Center
Baraga, Michigan 49908

Dear Mr. Holappa:

Attached is a copy of House Concurrent Resolution No. 298 as passed by the Michigan House of Representatives on June 17, 1987.

Senate concurrence on this piece of legislation is expected, however, not before the deadline for submission of your application to the Department of Health and Human Services.

Through my letter and HCR 298, it is our intention to support an appropriation in the amount of $500,000 for this very important and much needed Health Service Center.

I commend you for your efforts and look forward to hearing that work on the facility will begin shortly.

Sincerely,

D. J. Jacobetti

D. J. JACOBETTI, Chairman
House Appropriations Committee

DJJ:kk
Enc.

C: Dr. Everett Rhodes

Rep. Jacobetti offered the following concurrent resolution:

House Concurrent Resolution No. 258

A concurrent resolution expressing support for the construction of the Keweenaw Bay Clinic and New Day Treatment Center.

Whereas, The New Day Treatment Center and Tribal Health Center housed in the Keweenaw Bay Tribal Center in Baraga County, Michigan, are being threatened with closure due to many unsafe and hazardous conditions; and

Whereas, The State Fire Marshall has required the Tribal Center to bring the New Day Treatment Center, which was constructed in 1928, up to code; and

Whereas, The violations are too numerous and costly to consider renovation of the present structure; and

Whereas, Federal funds will be lost unless the State of Michigan matches the federal contributions; and

Whereas, The loss of both programs would have an extremely adverse affect on the delivery of basic health care to the reservation population and to the native American people of the Great Lakes region who now utilize the New Day Treatment Center; and

Whereas, The State Department of Public Health and the Substance Abuse Division support the construction of a regional drug and alcohol treatment center; now, therefore, be it

Resolved by the House of Representatives (the Senate concurring), That the Michigan Legislature supports the construction of the Keweenaw Bay Clinic and New Day Treatment Center; and be it further

Resolved, That we support an appropriation in the amount of $500,000.00 for this purpose.

R 1392 '87

STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor
OFFICE OF SUBSTANCE ABUSE SERVICES
3423 N. LOGAN, P.O. BOX 30035
LANSING, MICHIGAN 48909
ROBERT C. BROOK, Administrator

June 30, 1987

Mr. Ted Holappa
Health Services Director
Keweenaw Bay Tribal Center
Baraga, Michigan 49908

Dear Ted:

As we have stated previously, OSAS continues to be interested in efforts to provide cost effective and efficient substance abuse services to Michigan's Indian population.

In our May 20, 1987 letter to Mr. Mark Perrault, we stated that OSAS supports Keweenaw Bay's most recent efforts to improve the quality of the physical environment for recipients of services by constructing a new treatment facility. As soon as the requested federal funding is awarded to Keweenaw Bay for facility construction, this Office will plan to provide up to $100,000 in state monies to purchase necessary equipment and furnishings. Provision of this amount will, of course, depend on receipt of federal construction monies and availability of state monies.

We agree that an improved physical environment will be more conducive to achieving positive outcomes for your client population. If we can be of any further assistance, please do not hesitate to contact me.

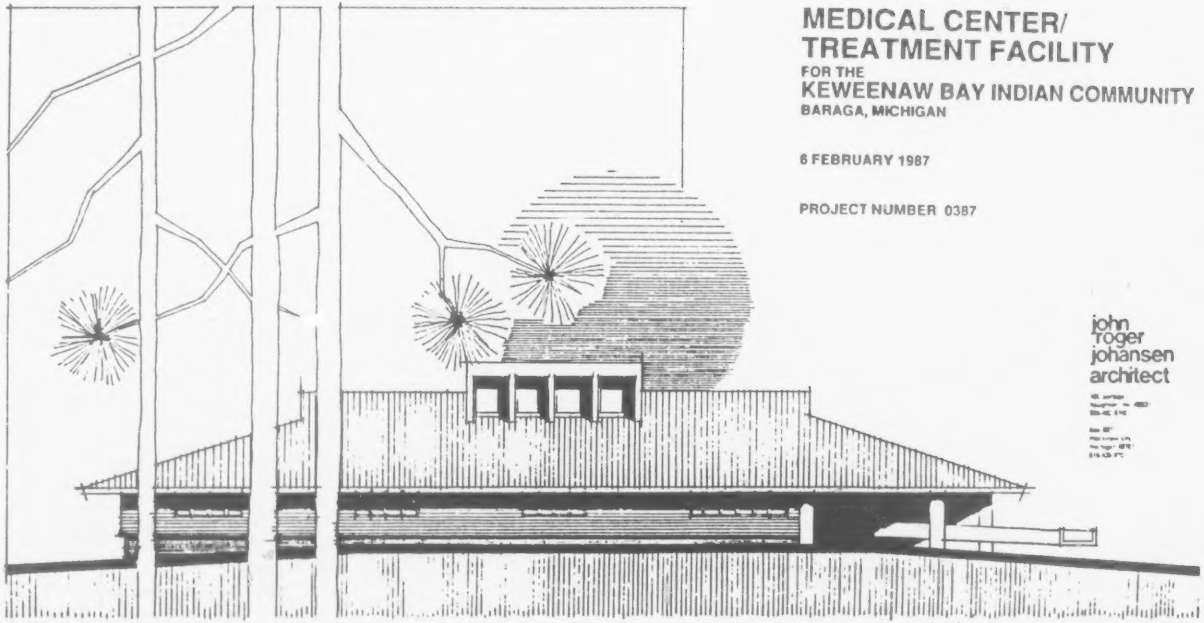
Sincerely,

Bob

Robert C. Brook
Administrator

cc: Judith Pamp
Mark Halkola
Judith Pasquarella
Jane M. Christensen

YES M!CH!GAN

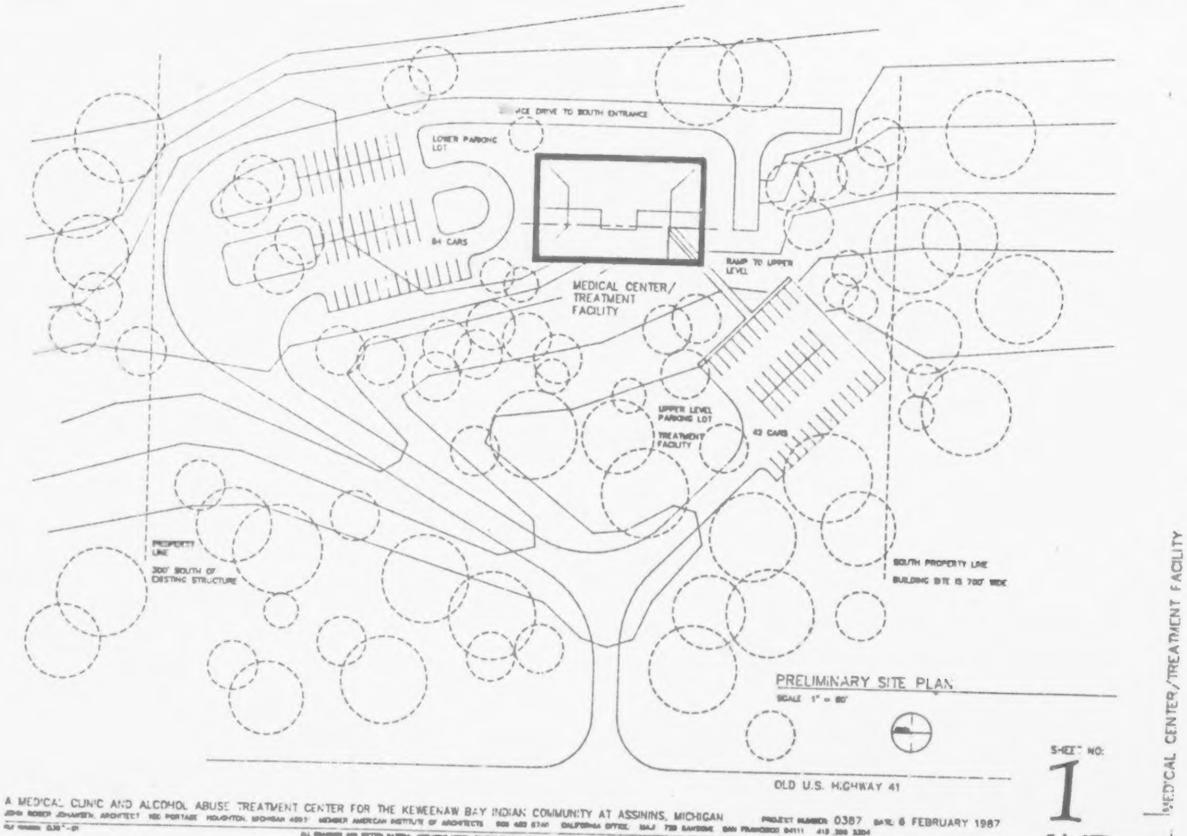


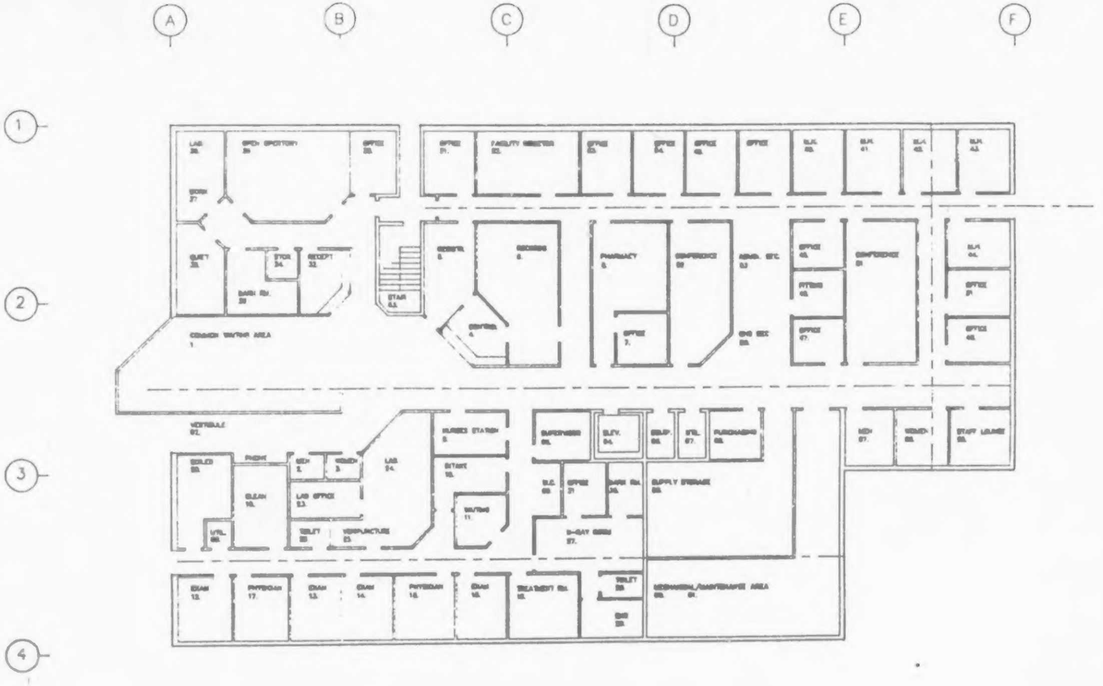
MEDICAL CENTER/
TREATMENT FACILITY
FOR THE
KEWEENAW BAY INDIAN COMMUNITY
BARAGA, MICHIGAN

6 FEBRUARY 1987

PROJECT NUMBER 0387

john
roger
johansen
architect


CE DRIVE TO SOUTH ENTRANCE
LOWER PARKING LOT
84 CARS
MEDICAL CENTER/ TREATMENT FACILITY
RAMP TO UPPER LEVEL
UPPER LEVEL PARKING LOT
TREATMENT FACILITY
42 CARS
PROPERTY LINE
300' SOUTH OF EXISTING STRUCTURE
SOUTH PROPERTY LINE
BUILDING SITE IS 700' WIDE
PRELIMINARY SITE PLAN
SCALE 1" = 80'
OLD U.S. HIGHWAY 41
SHEET NO:
1
OF 8 SHEETS
MEDICAL CENTER/TREATMENT FACILITY
A MEDICAL CLINIC AND ALCOHOL ABUSE TREATMENT CENTER FOR THE KEWEENAW BAY INDIAN COMMUNITY AT ASSININS, MICHIGAN
PROJECT NUMBER 0387 DATE 6 FEBRUARY 1987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LAB
OFFICE
FACILITY DIRECTOR
STAIR
RECORDS
PHARMACY
CONFERENCE
COMMON WAITING AREA
VESTIBULE
NURSES STATION
SUPPLY STORAGE
MECHANICAL/MAINTENANCE AREA
STAFF LOUNGE
EXAM
PHYSICIAN
TREATMENT RM.

LOWER LEVEL FLOOR PLAN

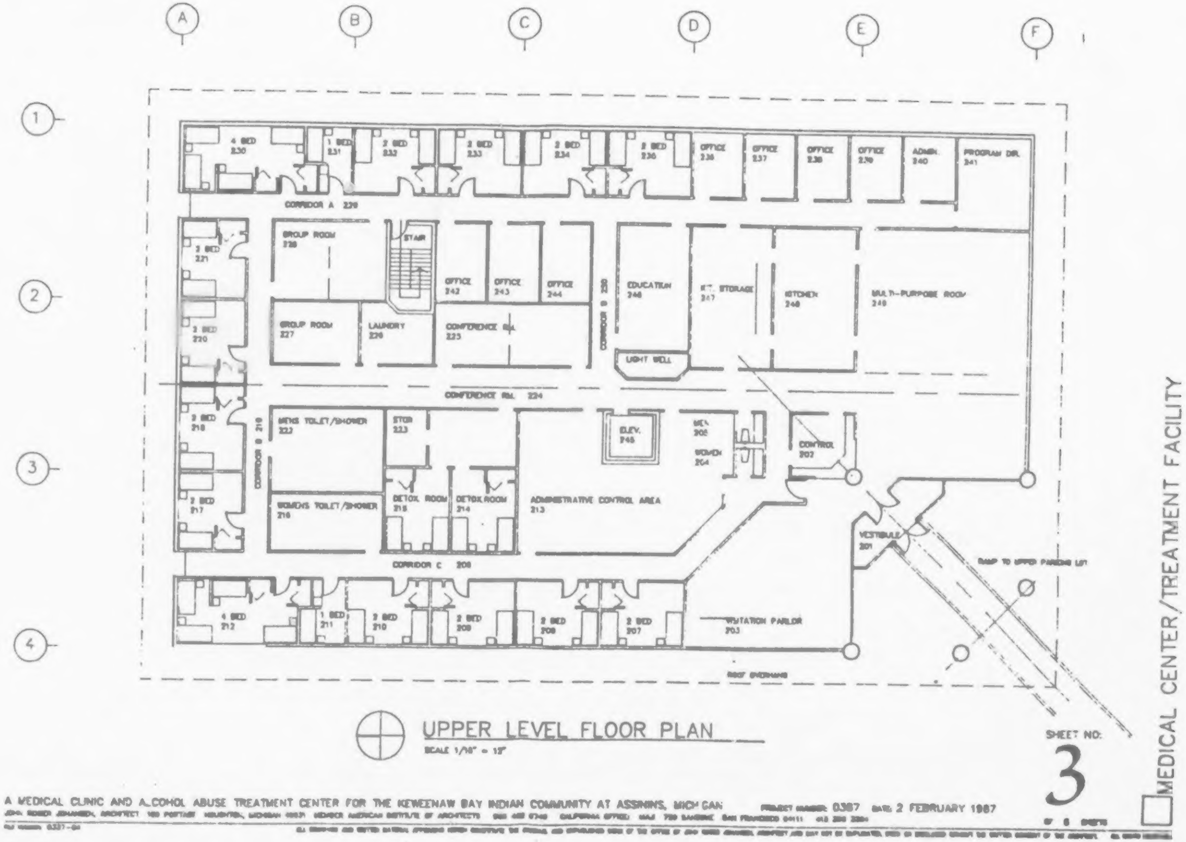
SCALE 1/16" = 1'0"

A MEDICAL CLINIC AND ALCOHOL ABUSE TREATMENT CENTER FOR THE KEWEENAW BAY INDIAN COMMUNITY AT ASSININS, MICHIGAN

PROJECT NUMBER: 0387 DATE: 6 FEBRUARY 1987

SHEET NO:
2

☐MEDICAL CENTER/TREATMENT FACILITY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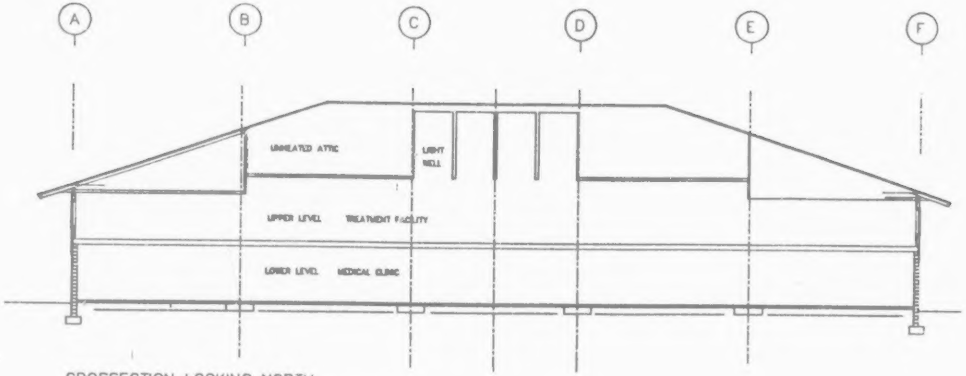
4 BED 230
1 BED 231
2 BED 232
2 BED 233
2 BED 234
2 BED 236
OFFICE 236
OFFICE 237
OFFICE 238
OFFICE 239
ADMIN. 240
PROGRAM DIR. 241
CORRIDOR A 229
2 BED 221
2 BED 220
GROUP ROOM 228
GROUP ROOM 227
STAIR
LAUNDRY 226
OFFICE 242
OFFICE 243
OFFICE 244
CONFERENCE RM. 225
CORRIDOR B 230
EDUCATION 246
LIGHT WELL
KIT. STORAGE 247
KITCHEN 248
MULTI-PURPOSE ROOM 249
CONFERENCE RM. 224
2 BED 218
2 BED 217
CORRIDOR B 219
MENS TOILET/SHOWER 222
WOMENS TOILET/SHOWER 216
STOR 223
DETOX ROOM 215
DETOX ROOM 214
ELEV. 245
ADMINISTRATIVE CONTROL AREA 213
MEN 205
WOMEN 204
CONTROL 202
VESTIBULE 201
RAMP TO UPPER PARKING LOT
CORRIDOR C 208
4 BED 212
1 BED 211
2 BED 210
2 BED 209
2 BED 208
2 BED 207
VISITATION PARLOR 203
ROOF OVERHANG
UPPER LEVEL FLOOR PLAN
SCALE 1/16" = 12'
SHEET NO:
3
OF 6 SHEETS
MEDICAL CENTER/TREATMENT FACILITY
A MEDICAL CLINIC AND ALCOHOL ABUSE TREATMENT CENTER FOR THE KEWEENAW BAY INDIAN COMMUNITY AT ASSININS, MICHIGAN
PROJECT NUMBER: 0387
DATE: 2 FEBRUARY 1987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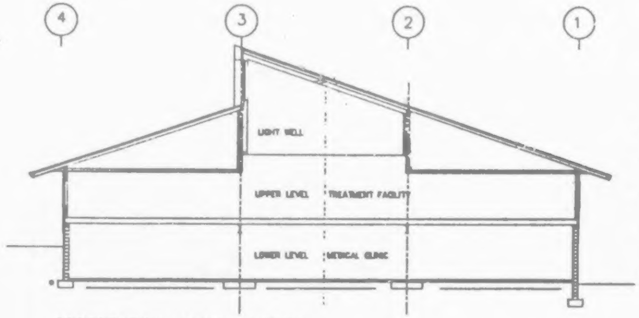
UNHEATED ATTIC
LIGHT WELL
UPPER LEVEL
TREATMENT FACILITY
LOWER LEVEL
MEDICAL CLINIC

CROSSECTION LOOKING NORTH

SCALE 1/16" = 12"


4
3
2
1
LIGHT WELL
UPPER LEVEL
TREATMENT FACILITY
LOWER LEVEL
MEDICAL CLINIC

CROSSECTION LOOKING NORTH

SCALE 1/16" = 12"

ROOF SYSTEM

UPPER WALL SYSTEM

UPPER FLOOR SYSTEM

LOWER WALL SYSTEM

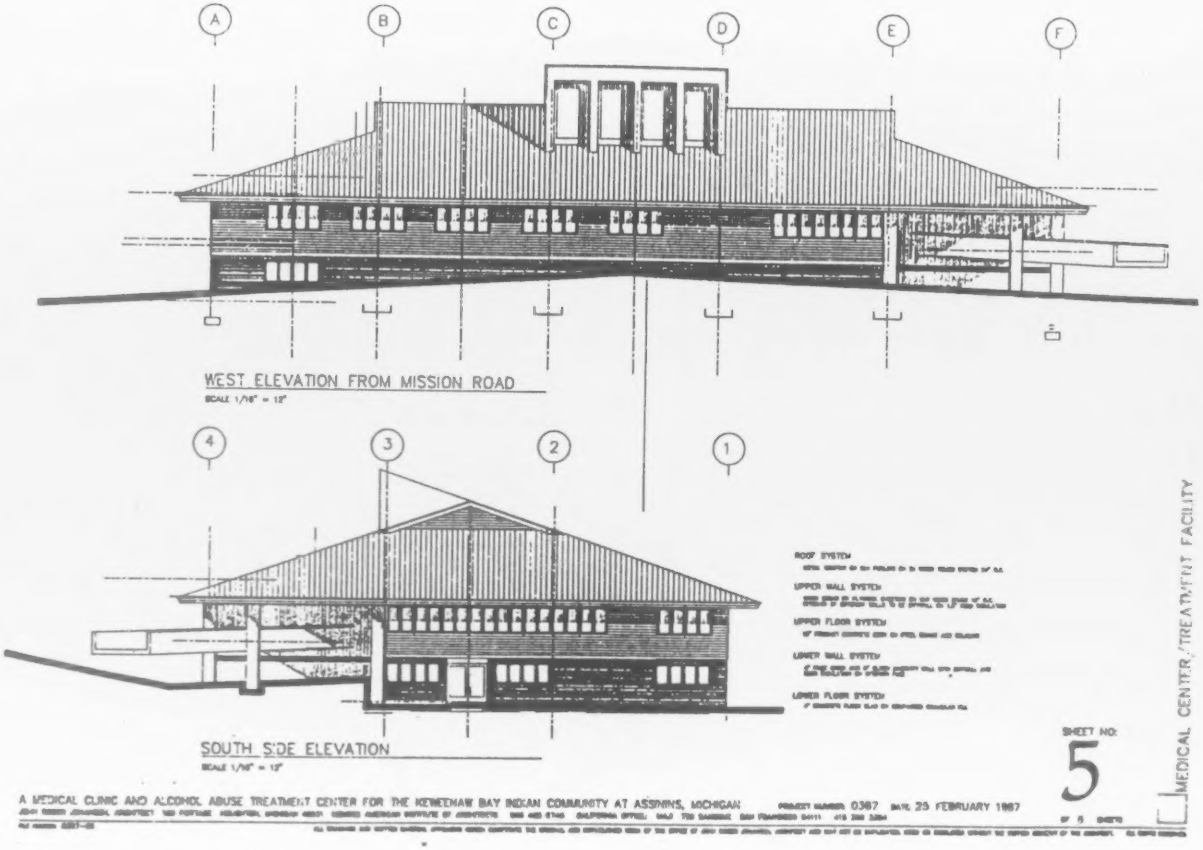
LOWER FLOOR SYSTEM

SHEET NO:

4

A MEDICAL CLINIC AND ALCOHOL ABUSE TREATMENT CENTER FOR THE KEWEENAW BAY INDIAN COMMUNITY AT ASSINNS, MICHIGAN PROJECT NUMBER: 0387 DATE: 24 JANUARY 1987

MEDICAL CENTER/TREATMENT FACILITY


A
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WEST ELEVATION FROM MISSION ROAD
SCALE 1/16" = 12"
4
3
2
1
SOUTH SIDE ELEVATION
SCALE 1/16" = 12"
ROOF SYSTEM
UPPER WALL SYSTEM
UPPER FLOOR SYSTEM
LOWER WALL SYSTEM
LOWER FLOOR SYSTEM
A MEDICAL CLINIC AND ALCOHOL ABUSE TREATMENT CENTER FOR THE KEWEENAW BAY INDIAN COMMUNITY AT ASSININS, MICHIGAN
PROJECT NUMBER 0387
DATE 25 FEBRUARY 1987
SHEET NO:
5
OF 5 SHEETS
MEDICAL CENTER/TREATMENT FACILITY

Karl A. Funke & Associates, Inc.
729 Second Street, N.E. • Washington, D.C. 20002 • (202) 544-4166

April 18, 1990

The Honorable John McCain, Vice Chairman
Senate Select Committee on Indian Affairs
838 Hart Office Building
Washington, D.C. 20510

Dear Senator McCain:

The Keweenaw Bay Indian Community asked me to forward the enclosed description of the New Day Alcohol Treatment Center. The New Day staff prepared the enclosed summary of the program in response to your request for additional information at the IHS Facilities Oversight hearing on March 22, 1990. It seems that the primary factor for the success of the New Day treatment center is based on the trained Indian staff.

On behalf of the Keweenaw Bay Tribe, thank you for your interest in the New Day Treatment Program and in the overall issues of Indian health, particularly the problems associated with IHS facilities. The March oversight hearing held at your request was, in our opinion, highly productive. W would like to compliment your staff for an excellent job of preparation. We are looking forward to working with you and your staff to develop and support legislation to address some of the problems associated with IHS Facilities construction.

Once again, thank you for your interest and concern for Indian people.

Sincerely,

Clara Spotted Elk
Vice Chairman

Enclosure
c.c. Chairman Dakota
Pat Racette, Director of New Day Treatment Center

NEW DAY TREATMENT CENTER NARRATIVE

The Keweenaw Bay Tribal Council Alcohol Program, otherwise known as the New Day Treatment Center,(Oshki Gi Jigah is our Indian name)is located just north of Baraga on U.S. 41. The program, which is housed on the third floor of the 62-year old tribal center building, began as a halfway house almost 16 years ago. From the beginning New Day served Indian people from the entire state of Michigan. As time went on it was realized that Indian people require more intensive treatment than a halfway house, and that Indian people were coming to New Day for treatment rather than participating in treatment in non-Indian facilities. In March 1977 New Day changed from a halfway house modality to a primary residential treatment modality in order to better serve the Indian population. Being the only Indian treatment center in the entire State of Michigan, New Day's reputation grew and referrals are also accepted from other states - primarily Wisconsin and Minnesota. Indian people have also come from Pennsylvania, Kansas, Illinois, and Indiana. Non-Indian clients are also given treatment services at New Day, however Indian clients are our top priority.

In 1987 an Outpatient-Aftercare Counselor/Prevention Specialist was added to the staff. This person provides outpatient substance abuse counseling for youth and adults, and does aftercare counseling for local individuals who have already completed treatment, and also presents prevention programs to school groups, Head Start classes, and to other organizations. Types of programs that might be presented are BABES, or Stress Management.

Staffing at New Day consists of a Program Director, Counseling Supervisor, three Treatment Counselors, Secretary/Data Coordinator, Assistant Secretary, House Manager, three full time Unit Managers, 5 part time Unit Managers, one half time Alcohol Educator, one Outpatient-Aftercare Counselor/Prevention Specialist, and one Cook. At intervals one of the full time unit managers is brought in as a Counselor Trainee, given a small caseload and on the job training. Each staff member is required to obtain the FSAC (Fundamentals of Substance Abuse Counseling) which is required by the State of Michigan Office of Substance Abuse Services. Three of the staff have obtained the Certified Addictions Counselor (CAC) certification from the State of Michigan.

Services that a client can expect while at New Day are intake and assessment, one-to-one counseling, group therapy, alcohol/drug education, AIDS assessment and education, recreational activities, and A.A. meetings, milieu therapy, didactic presentations, reading groups, and daily house meetings. Spiritual counseling and learning of traditional Indian ways are also available through community members. Transportation is provided for clients who need medical services that are not available in the tribal center clinic, for travel to A.A. meetings, for travel to church services, and travel to local events such as pow wows, intergroups, and sobriety dances.

New Day's Alcohol Education Department has an extensive film, slide, video and literature library. Many subjects are presented and discussed by the educator in a group which meets Mondays through Fridays each week.

As a non-profit organization, New Day's main objective is to help those with alcoholism/chemical dependency problems. Not being affiliated with a hospital nor having hospital standards has been a problem since most insurance companies will not pay for treatment under our present physical (building) conditions. New Day is able to bill Medicaid under a pilot project through the Office of Substance Abuse Services, however there is a yearly ceiling on the amount that can be billed. The majority of the clients served are on General Assistance grants through the Michigan Department of Social Services. Some clients are not eligible for the General Assistance grants and many times do not have the funds to pay for room and board during treatment. Some small donations are received yearly and these funds are used for room and board for some of these individuals.

It is felt that New Day has a number of unique qualities. The first and foremost of these are its staff, which is comprised of Indians and non-Indians (53% & 47% respectfully). Of the non-Indians 5 have Indian spouses. Therefore 79% of our staff have a vested interest in Indian issues. The majority of our staff are recovering alcoholics/chemical dependents, (68%) and a number of them (54%) are alumni of New Day. All staff have or are in process of attaining a level of certification. Also a number of our staff practice their Native American spirituality and cultural ways, so therefor become a valuable reference and resource for those clients that are searching for their native heritage.

Another area that I feel is unique is our treatment process. This process came about because of the difference between the increasing cost of living and funding sources inability/unwillingness to increase program allocations. This is what I call the "Inverted Ripple effect". The analogy would be that of dropping of a pebble in a pond and the effects on the water rippling outward, in this case the inward or opposite direction. We were then forced to find or develop a treatment process that would allow us to give quality services with a minimal amount of staff, so therefore we decided to change our primary focus of individual counseling to a group format. At present our treatment Program uses a group orientated process from admissions to discharge. This means that we have a cyclic admissions and discharge periods, in three (3) week intervals. This process allows a client to build trust in others, face their fears of others, and minimizes isolation. We believe that there are issues that are best identified and dealt with (in the beginning of treatment) in one to one counseling, e.g. sexual abuse, incest, etc. However we find that as the group trust level grows, individuals bring these issues into group (with their counselors agreement) and the clients find support and understanding which are essential to the healing process. Our six (6) week treatment process uses the same modalities commonly found in all rehabilitation units as mentioned in the previous page. However our uniqueness in this area is our sensitivity to cultural issues, beliefs, and understanding the spiritual meanings of ceremonies an other cultural activities, coupled with the ability to provide a client the availability of these resources.

New Day Treatment Center Statistics over the last five years.

Total Admitted	Discharged with Staff Approval	Male	Female	Indian	Non-Indian
100%	71%	80%	20%	84%	16%
860	611	667	175	714	141

We anticipate that 50% of those that complete our program will remain sober for a extended (Two years or more) period of time. That another 30% will show benefits of their having received treatment services, by changes in their behaviors, (e.g. less Legal, Social, Employment problems.) however may be drinking sporadically.
That of the remaining 20% most will have returned to drinking within the first 3 to 6 months however will show treatment benefit by seeking services (outpatient, or halfway house etc.) in a more timely manner.

Alcoholism and chemical dependency primary residential treatment services in a program especially for Indian people are not available in any other program in Michigan. The hope is that these services will continue in a new and modern setting for many years to come.

Thank you for you consideration in this request for funding for a new facility. Should you have any further concerns/questions, please feel free to contact me.

Patrick Racette
Program Director
New Day Treatment Center
Rt. 1, Box 45
Baraga, MI 49908
907-353-6623 Ext. 40

TESTIMONY OF JASPER HOSTLER, JR, VICE CHAIRMAN

HOOPA VALLEY TRIBE OF CALIFORNIA

BEFORE

THE U.S. SENATE SELECT COMMITTEE ON INDIAN AFFAIRS

March 22, 1990

Good morning, Mr. Chairman. My name is Jasper Hostler, Jr. and I am the Vice Chairman of the Hoopa Valley Tribe of California. Appearing with me today is Mr. Peter Masten who is the Executive Director for our Tribe's Hupa Health Association. Also appearing with me is Mr. George Koortbojian of the St. Joseph Health System, Eureka, California, and Mr. Vic Biswell, Association of California Hospital Districts, who are currently conducting a feasibility study on our development of a Comprehensive Health Care Plan. They will testify on the technical aspects of our health care system.

On behalf of my Tribal Council and our Tribal members, I would like to thank you for the opportunity to testify today regarding the problems we have experienced with the Indian Health Service's (IHS) Facility Priority construction and renovation methodology. I want to express our Tribe's specific interest in joining with you in a demonstration project that produces a creative model for increasing the level of rural health care to small Tribes like Hoopa. As you will see from my testimony and the information we submit the record, we believe the situation at Hoopa is ready-made for such a demonstration project. We have an existing hospital facility that was closed-down in the late 1980s. We have documented some of the costs for renovation. We are in the middle of an ongoing feasibility study. Our medical needs are critically urgent. We have a soundly operated clinical program. And our Tribal Council is ready, willing and able to broaden its self-governance powers and manage an expanded health program.

First, I would like to provide the Committee with a brief overview of the history of the hospital facility and health care system on our Reservation and surrounding communities. The Hoopa Valley Indian Reservation, the largest in the state, was established in Northern California by a presidential Executive Order in 1864. Because the 1864 Act authorizing the Reservation required the federal government to put a physician on the Reservation, the Indian Bureau constructed an Indian medical dispensary and later built a hospital at Fort Gaston, a U.S. military outpost on the Reservation. In 1916 that health program was moved to another location on the Reservation where a 15-bed Hoopa hospital was built; in 1937, it was enlarged to 29 beds.

During the 1950s, the federal government began developing its Indian termination policy. Part of the termination plan was to remove all Indian hospitals from reservations, including our Hoopa Hospital. Under the termination threat of a complete elimination of our Reservation health services, a group of local residents formed the Community Health Association (CHA) at Hoopa in 1953. During this period, the Bureau of Indian Affairs transferred control of our hospital to the U.S. Public Health Service, Indian Division (PHS). After we attempted unsuccessfully to get the hospital operations transferred from PHS to the CHA, PHS began closing down our hospital.

In 1958, we began to negotiate with various groups to build a new hospital on our Reservation to be operated by the CHA. In early 1960, our present Hoopa Hospital facility was completed under a cost-sharing formula of three-sixths being paid by the Public Health Service, one-sixth by federal Hill-Burton funds, one-sixth by state Hill-Burton funds and the remaining one-sixth by the community. The community contributions were truly spectacular. People at Hoopa -- professional plumbers, electricians and others -- contributed their labor. An individual donated four acres of fee land on our Reservation for the hospital. Sawmills donated lumber. One of our medical doctors, Dr. Ricklefs, even appeared on a national television show, This is Your Life, generating contributions from throughout the United States.

The CHA operated our hospital for more than a decade, but as the medical field evolved, the CHA began operating at a loss. In 1972, the county government assumed operations of the hospital. Then in 1978, a California state-wide tax initiative forced a sharp reduction in local government spending on all health programs, at which time the county began to transfer Hoopa Hospital operations to private health care enterprises.

In 1986, one of these private health care managers, West World, Incorporated, closed down our hospital's in-patient operations. In 1987, West World filed for bankruptcy and pulled out entirely. The next manager was the Mad River Community Hospital of Arcata, California. Mad River restructured and reduced services by eliminating all in-patient services in order to make a profit. Mad River maintained only the emergency room and lab services. Mad River held the facility license but initially provided only weekend emergency room coverage. The Hupa Health Association clinic provided emergency room physician coverage during the week, under the Mad River licensing authority. Only a few months after Mad River assumed the license and began to operate limited services at our Hospital, Mad River announced it had decided to completely abandon our facility.

By this time, our unmet medical needs ~~had become~~ extremely acute. Our Tribe negotiated with Mad River an agreement whereby the Tribe and the Hupa Health Association would subsidize Mad River's for-profit operation of our emergency room, laboratory and x-ray services, on a temporary basis. The Tribe provided a $25,000 subsidy for a four month period. The Hupa Health Association provided a subsequent subsidy of $29,000. Then in April, 1988, as a response to its ongoing litigation with our Tribe, the Bureau of Indian Affairs completely froze our Tribe's total budget, including our own money from our own timber revenues. This abruptly terminated our ability to provide a subsidy for essential hospital operations. Mad River immediately closed down its operations at our Hospital, stripped our Hospital of its equipment, and left our Reservation with an empty, inoperable facility and no emergency room, lab or x-ray services.

Hoopa tribal representatives had already been discussing our health program problems with the IHS California Area Office (IHS/CAO). When Mad River shut down our Hospital, the Hoopa Tribe and IHS were faced with a crisis situation: vital services had been abruptly terminated creating life-threatening situations. IHS/CAO provided funds to purchase x-ray and lab equipment but did not provide funds for emergency room operations.

This has meant that from that time to today, there are no emergency room services or in-patient services on our Reservation or in the surrounding community. All emergency care patients must be transported to the coastal cities of Arcata or Eureka, nearly 60 miles from the central part of the Reservation. These distances are even greater for many residents of our community living away from the center of the Reservation. The only hospital in Arcata is Mad River, the very health care provider that abandoned us. The emergency medical system has designated Mad River as the hospital where our ambulances are supposed to deliver emergency patients.

The Hupa Health Association ambulance service averages 1.2 responses every twenty-four hours. We have only very infrequent access to helicopter ambulance services (an average of one or two flights per year by a U.S. Coast Guard chopper). At a minimum, it takes an ambulance vehicle more than one hour in good weather to get to the Arcata hospital, over steep and narrow mountain roads which are usually closed several times each year due to snow or slides and are dangerously icy during much of the winter.

After Mad River closed our hospital, our Tribe's health program picked up the patient load of the hospital while maintaining its previous patient load. This compounded the fact that over the past decade patient visits to our clinic have increased by 264.0 percent. We expanded our clinic hours for a while but because of funding shortages we had to cut back these services again. Our clinic is severely overcrowded and our doctors and clinic staff are terribly overworked. Our ambulance program is running at a substantial deficit because the extra time required to get to off-Reservation emergency hospitals has forced us to hire additional staff simply to maintain previous levels of emergency coverage. The Ambulance Administration and Staff Quarters are housed in dilapidated mobile home trailers.

In addition to our out-patient medical and dental clinics, and our ambulance program, our Tribe is served by a number of other programs like home health care and alcoholism rehabilitation. While these services are doing the best that they can to meet the needs of our people, our existing staff is not presently equipped to assume all of the responsibilities previously met by the in-patient facility. This is because both the IHS and the Tribe designed our clinic, ambulance, and other health care services to complement and not duplicate the services previously provided by the hospital. For example, our ambulance team was and is funded, staffed and equipped to handle runs averaging 30-40 minutes, not three to four hours. There are still a number of hours during any given day when our families and friends have no local access whatsoever to emergency health care.

After many discussions with IHS personnel, our Tribe has come to the realization that the only way our community will ever regain the basic services it requires is if we address and solve the problems ourselves. With this goal in mind, the Tribe began meeting with the Community Health Association (CHA) to see whether there was any possibility that the CHA could reopen the hospital as a full-service, acute care facility like its previously operated in the 1960s. The CHA could not do so. Together, the Tribe, our Hupa Health Association, and the CHA formed the Hoopa Ad Hoc Hospital Committee, which I chair, to study the current needs of our Indian and non-Indian community and develop a responsive plan. As part of this effort, the CHA has formally transferred title to the hospital and the land on which it sits to the Hoopa Valley Tribe.

We were dismayed when IHS told us that the facility priority list methodology would bar us from ever having any hope of getting IHS construction and renovation funds, simply because the population in our service area of 3,800 Indians is too "low." Even worse, federal law appears to prohibit us from using our hospital building, regardless of who pays for the renovation, unless we meet impossibly high IHS standards which were never intended to address situations like those existing at Hoopa.

Today our Hoopa Hospital sits vacant some 200 feet away from our overcrowded outpatient clinic swollen by patients, many of whom previously would have been treated in the Hospital. As a result, our health care system is being overwhelmed by need that is growing as rapidly as the space and funds are diminishing. Because by the IHS criteria our health service area is too small and too remote to score well on the IHS needs assessment methodologies, our community has been legislatively and bureaucratically prevented from developing any real remedies to our problems.

We at Hoopa know that similar problems exist in other parts of Indian Country. The IHS California Area Director, T.J. Harwood, in his Health Facility Priority System Report to the IHS Central Office dated December 5, 1988, stated, "We would like to explore the possibility of designing the criteria for small facilities, which would make them better able to compete in the existing priority system. Perhaps with your assistance, we could design a 'model' which would be applicable to the smaller health centers." Also, the Director, IHS Regional Office of Facilities Engineering and Construction, wrote in his 1980 report concerning the Hoopa Hospital that: "Geographical considerations dictated the need for this hospital. Hoopa is sixty odd miles over narrow steep twisty roads from the hospitals in Arcata and Eureka.... It literally makes the difference between life and death for accident victims."

Because IHS does not have a "model" for rural Indian programs and because of the constraints imposed by 25 U.S.C. §1631, et seq., IHS does not appear able to address this problem. In establishing the facilities renovation and construction priority list methodology, Congress and IHS developed a rigid system that simply does not fit the real world of rural Indian programs. As a result, the people at Hoopa suffer because we don't fit the model.

Mr. Chairman, we at Hoopa are ready to build our own model. We have much going for us. Thirty years ago, our entire community demonstrated its ability and good will in building our Hospital. Since then we have suffered at the hands of other people who have run our Hospital for us and done us in. Our only hope is to take it back and run it ourselves, in a way that fits our needs and today's realities. We are ready to do this. We recognize that adjustments will have to be made to fit changing medical and economic realities, such that we will not have the same kind of operation we previously had at our Hospital. But it makes economic and medical sense to provide essential health care, including emergency room services, to our community.

We have already begun a feasibility study. A "Deep Look" study conducted by IHS last year roughly estimated that the renovation cost to bring our closed-down Hospital to operating accreditation standards would be $925,000, coupled with $335,000 to do the same for our ongoing clinic facility. Ours is the only such Indian hospital in California.

Like in the 1960s when we built our Hospital, it will take a partnership of tribal, federal and local governments. But it is clear to us that our tribal government must take the lead if this project is to succeed, not only because we are now in an era of tribal self-governance but also because we have painful experience with the fact that allowing others to do it for us does not serve our best interests. To bring together all these players into a successful, soundly planned and executed package, however, requires that overall management and control be placed in our tribal government. We believe it is critical that a tribal demonstration health project support such tribal control and oversight, with funding for both developmental planning and technical assistance as well as long-term planning which leads to a secure operational funding base.

It is obvious to us that unless Congress and IHS begin to take this situation very seriously, we all will be faced in the near future with a total collapse of small, rural health programs in Indian Country.

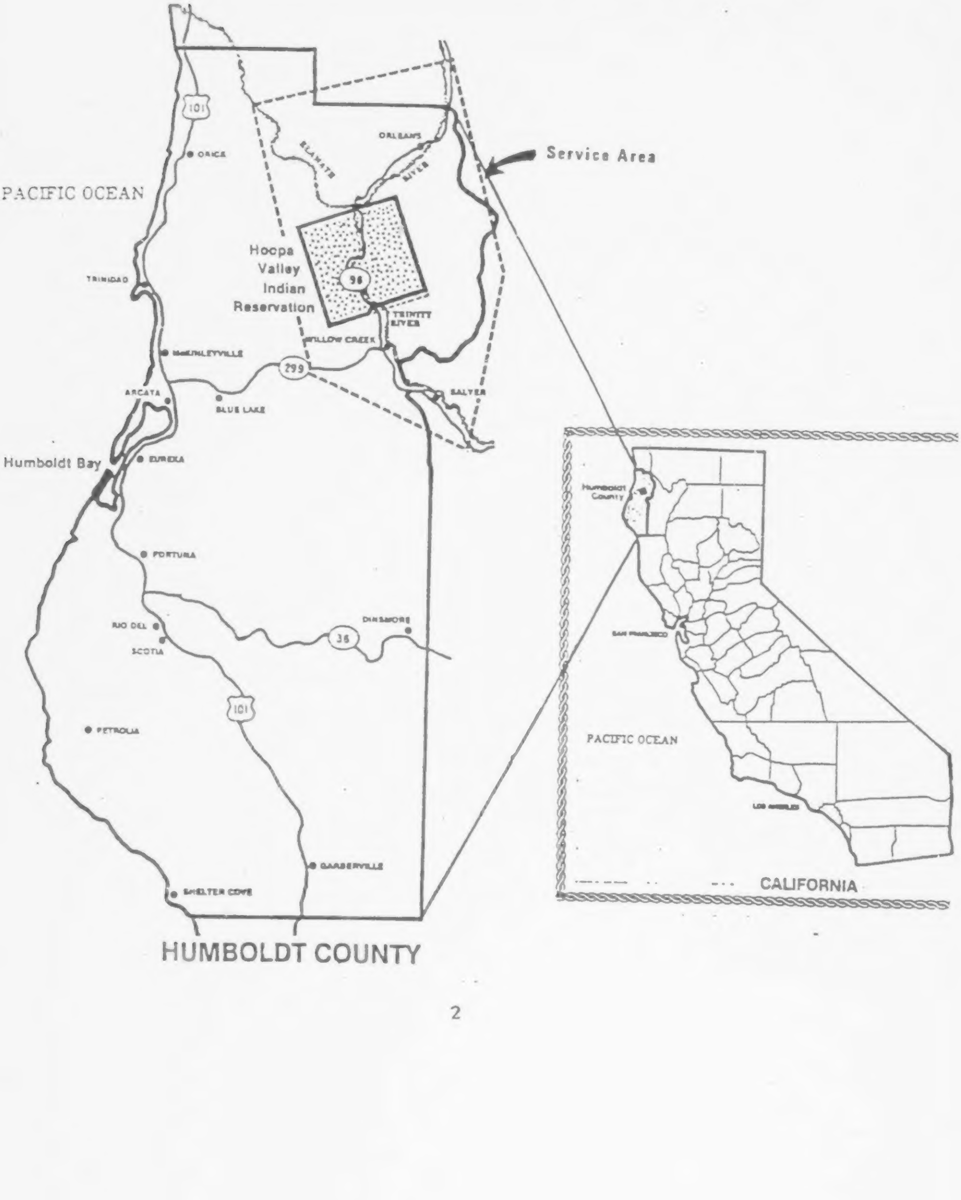
We are willing to participate with you in finding the solutions. But Congress must require IHS and other federal agencies to permit tribal governments the flexibility to address these problems and not tie us up with restrictions and requirements that simply do not fit our small, rural situations.

Hoopa would be delighted to assist your staff in developing this legislation and in setting up a demonstration model which would permit broad powers of tribal self-governance so that, without bureaucratic encumbrance, a demonstration model can be explored and discovered that will lead to a program that can be repeated in many different small, rural Indian communities.

I would like at this time to ask that you permit Mr. Koortbojian and Mr. Biswell to briefly explain some of their findings so far in our ongoing feasibility study. Mr. Masten and I would be happy to answer any questions you may have.

HOOPHOS1.TES
0020/07134

Location Map and Service Area
HUPA TRIBAL HOSPITAL & MEDICAL CENTER


Service Area
PACIFIC OCEAN
101
ORICK
ORLEANS
KLAMATH
RIVER
Hoopa
Valley
Indian
Reservation
96
TRINIDAD
TRINITY
RIVER
WILLOW CREEK
McKINLEYVILLE
299
ARCATA
BLUE LAKE
SALYER
Humboldt Bay
EUREKA
FORTUNA
DINSMORE
RIO DELL
SCOTIA
36
101
PETROLIA
GARBERVILLE
SHELTER COVE
Humboldt
County
SAN FRANCISCO
PACIFIC OCEAN
LOS ANGELES
CALIFORNIA

HUMBOLDT COUNTY

TESTIMONY BEFORE THE SENATE SELECT COMMITTEE ON INDIAN AFFAIRS

MARCH 22, 1990

"Hoopa Health Project & Alternative Rural Hospital Models"

Mr. Chairman and members of the Committee, I am George Koortbojian from St. Joseph Health System and with me is Vic Biswell from the Association of California Hospital Districts. We are both working with the Hoopa Tribe and the local community to revitalize the health delivery system in the Klamath-Trinity area of northwestern California. This includes a 16 bed acute care hospital located on the Hoopa Reservation which will probably not operate again as a full-service acute care facility.

Given the purpose of this hearing, we are here today to discuss some of the dynamics of the Hoopa project as well as describe some viable alternatives for the hospital and others like it.

The people of Hoopa are committed to developing programs and services which meet community health needs. Despite a history of service fragmentation, abandonment by outside providers, and a shortage of resources, the community remains resilient. They have organized to address health care problems and welcome your interest and support.

Since the early 1980's, hospital based health services have been provided by groups from outside the community. Often these groups duplicated services provided by the Hupa Health Association. This further fragmented patient care and increased overall health costs. In June 1988, the last in this series of providers left the community. The hospital and its emergency department were closed. Today, patients requiring life-saving procedures must travel more than an hour to obtain emergency care. These patients are then confined away from home, family and community support. This situation is unacceptable.

The Hoopa Valley Business Council has taken a leadership role in re-establishing hospital based health care services. They have emphasized the need to include all community members; Indian and non-Indian. They seek to create a new integrated model for health care delivery. This model will be community based and specifically designed to meet local needs.

Our initial approach consists of identifying local needs and evaluating existing services. This process includes a formal survey of community members and informal meetings with the public. All current health care expenditures are being reviewed. We recognize that resources will continue to be constrained and therefore plan to eliminate service duplication or inefficient use of current funding. The third component of our project is the review of health service utilization. This retrospective look at actual service use will enable a better molding of future programs.

These data: financial, utilization and community needs, all form the baseline for making objective decisions about future health care. Given the above, it is our opinion that the alternative rural hospital model offers the best opportunity to achieve improved access to health care and elevate the health status of the community.

Alternative Rural Hospitals

Many Californians who primarily work with rural hospitals have recognized for some time that at least one third of our 83 defined small and rural hospitals could not survive the early 90's functioning as full service acute care institutions. Because of scale economies, compounded by the reimbursement system, it became very apparent as early as 1984 that we had to identify a rural alternative that would preserve access to acute care services and stabilization services and yet be cost effective. It took until 1988, however, to pass state legislation which would accomplish this. In California we have now developed and tested an Alternative Rural Model (ARM) which we believe can meet the needs of many of our rural communities and, at the same time, operate close to a break even point. This California model, coupled with the Rural Primary Care Hospital authorized by the Omnibus Budget Reconciliation Act of 1989, provides at least two possible alternatives for situations like those which exist at Hoopa.

The California model does not require any waivers from the Medicare Conditions of Participation and, therefore, has potential for application in other settings outside of California. It is straightforward and very flexible in that it uses a building block approach in addressing a given community's specific service needs. It starts with a set of core services which include:

- standby emergency medical services
- basic medical holding/stabilization capacity
- basic laboratory services
- basic radiology services.

To these core services, service modules may be added as needed. These include:

- expanded inpatient services
- selected inpatient and outpatient surgical services
- obstetric services
- expanded radiology.

The model was tested at two sites and simulated at a third. In the case of the two test sites, both of which were isolated 18 bed hospitals with some skilled nursing services, modeling outcomes indicated that both facilities would generate small operating gains within the current reimbursement system. In the case of the simulated hospital, its fiscal health would have improved significantly but it would have not quite reached a break even point. We will provide your staff with a copy of the Final Report on the California model.

The other alternative rural hospital model -- the Rural Primary Care Hospital -- commonly referred to as the PCH ("peach"), was authorized by the Omnibus Budget Reconciliation Act of 1989 for testing in 7 states and 15 other sites. This program is not yet operational and it is anticipated that it will be next fall before this happens. This model is somewhat more restrictive in that it limits the number of acute beds to six, has a 72 hour length of stay, and places certain affiliation requirements on the hospital. A significant benefit of this program, however, is that PCH hospitals will essentially be reimbursed at cost.

Both models, and variations of them, can provide workable alternatives to current hospital situations on and off reservations. A key ingredient, we believe, will be the extent to which such alternative hospitals become the "hub of health" in the communities they serve. In many rural areas more than one organization may be providing varying types and levels of service. This can lead to bifurcation or even trifurcation of effort. Lab and X-Ray services, for example, should not be duplicated in a rural clinic which is in the proximity of the rural hospital. Ancillary services should be the "bread and butter" of the rural hospital. It makes sense to use underutilized hospital space and ancillaries for many outpatient diagnostic and curative services as well as wellness services. The community also needs to "learn" to focus on, and support, one coordinated resource. This must be the alternative rural hospital so that we can afford to continue to provide access to acute care and stabilization services in isolated, rural communities.

In the Hoopa situation, an alternative rural hospital model will work well. Such a facility will become the "hub of health" because of the dynamics which Mr. Koortbojian has described.

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TESTIMONY
OF
ALAN PINKHAM, CHAIRMAN OF THE NEZ PERCE TRIBE OF IDAHO
REGARDING INDIAN HEALTH SERVICE FACILITIES
BEFORE THE
U.S. SENATE SELECT COMMITTEE ON INDIAN AFFAIRS
MARCH 22, 1990

Mr. Chairman and members of this Committee:

My name is Alan Pinkham. I am the Chairman of the Nez Perce Tribe of Idaho. I am here today to testify on the Indian Health Service (IHS) approach to facility replacement, the difficulty my community has experienced in attempts to work within that system, and our recommendations to allow for innovative approaches to clinic replacement through cooperative agreements with tribal governments. In summary, the recommendations of the Nez Perce Tribe are as follows:

1. That the Senate Select Committee on Indian Affairs proceed to develop an alternative to the National Facility Replacement Priority System currently utilized by the Indian Health Service.
2. That this Committee provide for small communities (less than 10,000 population) a means to achieve facility replacement through leveraging of alternate resources, including financing, or other innovative means to provide space for IHS or tribally contracted health care services.
3. That this Committee instruct the Indian Health Service to allocate a portion of its facility resources area by area, to achieve equity and geographical distribution of facility replacement funding and to allow areas more discretion.
4. That this Committee support the Nez Perce Tribe in its effort to replace the inadequate facilities in Lapwai which currently houses the IHS clinic, and that this effort by the tribe to seek alternate financing be carried out in cooperation with the Indian Health Service as eventual tenant of this space.

BACKGROUND AND HISTORY

The original area inhabited by the Nez Perce people covers over 13 million acres of Idaho, Washington and Oregon. The Treaty of 1855 established this territory as our original land base. The United States Government later reduced our reservation boundaries to just over 750,00 acres under the Treaty of 1863. Our tribe maintains our rights to the ceded territory to exercise our cultural activities and access all usual and accustomed areas. The Nez Perce Tribe has a total tribal enrollment of 3,500 members, over half of whom reside on or near the reservation.

The Indian Health Service has been the primary provider of health services for our members. IHS provides direct care only on an outpatient basis. There is no Indian Health Service Hospital in the entire Portland Area (Idaho, Oregon, Washington). All inpatient care is provided through Contract Health Services (CHS) of IHS. As this Committee knows, Contract Health Services is a reimbursement based system to pay private health care providers for services delivered to eligible IHS patients who have received prior authorization for such care. Unfortunately, in the Portland Area CHS services have become so expensive in the private sector, and appropriations have been so limited, that only cases to save life or limb are approved for CHS payment. Most of our tribal members in need of hospitalization, if they do not fall into the priority one category are placed on a "deferred treatment" list. This means that they have to wait until there is enough money to pay for their hospitalization or until their condition develops into an emergency. This has proven to be a tremendous hardship for our tribe. As of March 1990, the number of people on the "deferred treatment" list for CHS paid hospitalization and specialty care was 683 and climbing. Without an IHS hospital or some other arrangement, this number will grow as the fiscal year continues or until additional dollars are identified for deferred treatment patients under Contract Health Services.

Outpatient Care is provided directly by the Indian Health Service at the Lapwai Clinic. The Northern Idaho Service Unit also maintains a nurse practitioner satellite clinic in Kamiah, and a tribal health program in Plummer. The Lapwai Clinic serves as the headquarters for the Northern Idaho Service Unit of the Indian Health Service. This Service Unit is responsible for the health care for the Nez Perce Tribe, the Coeur d'Alene Tribe and the Kootenai Tribe, covering the entire North-Central and Panhandle area of the state of Idaho. In addition to direct outpatient services provided at the Lapwai IHS Clinic, the facility also provides space for Contract Health Services activities related to all inpatient care for the three tribes, mental health counseling offices, a small dental clinic, environmental and sanitation staff for the three tribes and administrative space for the IHS service unit director and support staff.

There is inconsistent data regarding the total number of Indian people served by the Lapwai IHS Clinic. The Service Unit Director reports that the number of "active" charts, which includes anyone who has been served in the past three years, exceed 8,000 patients. Various Indian Health Service documents which we have collected describe the population served by the Lapwai IHS Clinic. Each IHS document we have examined has its own estimate on the service population. This is a serious problem for our community particularly in regards to resources allocation and facility replacement formula which utilize "service population" as a key criterion. IHS estimates have also been as low as 3,620 "Active Registrants" and as high as 9,400 "Estimated Indian Population for Northern Idaho".

CONDITION OF THE CLINIC FACILITY

The Lapwai IHS Clinic is a one story building with a full basement constructed of cinder block and concrete. It was built in 1970 originally to provide office space for the Bureau of Indian Affairs. The Indian Health Service began occupying the space for its direct service program. The building is approximately 5,000 square feet gross. Two office trailers have been pulled up next to the building to provide overflow for administrative space and tribal health programs. The most serious problem with the building is it is not functionally useful for health care delivery. The "U.S. Public Health Service Real Property Inventory" gives this description of the Lapwai Clinic:

Construction: Permanent Standard: Inadequate

The clinic contains only four functioning exam rooms. A small waiting area is located in the middle of the building and many patients wait in the hallways or outside. The restrooms are not accessible for the handicapped. One small 10' x 11' office is shared by two physicians, one nurse practitioner and a dentist for charting, telephone consultations and paper work. Storage space is virtually nonexistent and boxes, equipment, files, supplies and janitorial tools are often found in the hallways, exam rooms or restrooms when the space is needed. There is no room for confidentiality or privacy for patients in this building. The pharmacy operates out of a converted closet, with little privacy for patient instruction. A steep and dangerous stairway leads to the basement area. The basement, having only one stairway entrance, is a fire trap and in violation of fire safety codes. Yet, the basement is heavily utilized by both staff and patients. The Contract Health Services office is located in the basement and patients seeking authorization for CHS care must enter this unsafe area. Our elderly people are the primary users of CHS services, and the stairs are difficult for them. Pregnant women and women with infants and children also must use the basement area to access the Women, Infants and Children (WIC) program for nutrition counseling and food supplements.

The Portland Area Office of the Indian Health Service is responsible to assess the facility needs in the area. Annual facility assessments are to be conducted by area and service unit staff, and at least once every three years each IHS facility is supposed to receive a "Deep Look" assessment by a team of engineers, planners and IHS staff. The last "Deep Look" assessment conducted on the Lapwai IHS Clinic was in March 26, 1987. Numerous serious facility deficiencies were identified including "Life Safety Violations", handicapped accessibility barriers and a range of functional inefficiencies which prevent the adequate use of clinic space. The Indian Health Service reviewed the Lapwai IHS Clinic under much more liberal standards than would be required for an outpatient medical clinic. In their summary memo regarding this March Site Visit, IHS wrote:

> **"After a review of the use and function of the facility and an analysis of the fire and life safety codes, we confirmed the classification as a Business Occupancy rather than the more restrictive Ambulatory Health Care category..."**

The staff at the Portland Area have admitted to us that the findings of deficiencies would have been even more extreme had they reviewed our building under the Ambulatory Health Care category in stead of the Business Occupancy category, as it should have been. While IHS has since set a policy to review clinics under the Ambulatory Health Care category in the future, the severe facility needs as Lapwai have been understated in the "Deep Look" process to date.

In a recent survey by the Joint Commission for the Accreditation for Health Care Organizations (JCAHO), the Lapwai Clinic was assailed as unsafe with a list of deficiencies jeopardizing patient safety and continued accreditation for the whole service unit. The JCAHO survey team was originally scheduled to make their site visit to the Lapwai Clinic in November 1989. This visit had to be rescheduled because of a major flood in the Lapwai facility which occurred the day before their arrival, and forced the closure of the clinic while staff shoveled buckets of mud out of the basement area.

In 1988, Congress identified Medicaid and Medicare reimbursement funds which were to be used to repair and expand clinics like the one at Lapwai. Our tribe received a memo from Bill Pearson, the IHS Associate Director for Environmental Health and Engineering. It provided approval to proceed on needed repairs at Lapwai. But his memo went on to say:

> **"The present clinic has serious space deficiencies in all categories...This temporary space will resolve a critical problem until the facility is replaced in the normal permanent construction cycle."**

It has been two years since this repair project for Lapwai was approved. To date, no construction or repairs have occurred. IHS is currently in the bid process for repairs and temporary expansion at the Lapwai Clinic. The "temporary expansion" will provide prefabricated modular additions to the clinic. According to IHS, these modular units have a life expectancy of five years. The time it takes for tribal communities to meet the standards for consideration on the National Priority List for Facility Replacement and to receive adequate appropriations for construction of a replacement facility, will exceed the life of these "modular units" proposed by IHS for Lapwai. The planned repairs and expansion at Lapwai will not solve the problem of the facility size, design, overcrowding and dependence upon the basement space for patient services.

THE PROBLEM WITH THE PRIORITY SYSTEM

The suggestion that all Lapwai has to do is wait until the facility is "replaced in the normal permanent construction cycle", erroneously suggests that such a cycle exists. There is NO LIST that includes all the facilities in need of replacement. Communities should not be led to believe that they will "move up" on the list, because THERE IS NO LIST. There is an annual process which examines all the communities nominated from each of the IHS Areas and applies weighted criteria in a "national competition" of need. A handful of the communities which score the highest in this national run-off are forwarded to the House and Senate Appropriations Subcommittees for consideration of funding. The exact process and deliberations which occur at headquarters remains a mystery. A specific formula has been developed to weight the various nominations for facility replacement. Yet, local, area and headquarters staff can argue for exceptional situations to adjust the data, such as workload data, population data, access data or facility information to help particular projects. Communities that didn't make it onto the priority list one year do not automatically get moved up the next year. They have to be renominated again for a new annual review of the range of facility requests. Some IHS Areas do better in the competition than others. **Eighty-nine percent (89%) of all facilities built in the past ten years were in the Navajo, Phoenix, Aberdeen, Billings, Alaska or Oklahoma areas.** In the Navajo, Phoenix and Aberdeen areas alone 58% of the IHS hospitals ~~and clinics~~ were completed.

Portland Area Office staff have nominated the Lapwai Clinic to be replaced several times. The Nez Perce Tribe disputes the accuracy of the patient data utilized in the nomination. The deteriorating facility and the life safety violations at the clinic have caused the patient utilization to drop. Many patients will avoid going to the clinic as long as possible. IHS has estimated our patient population from 3,500 to 9,400. The size of the community to be served by the proposed new facility is a key criterion in the overall priority system process. The Nez Perce Tribe has been told by staff from the Portland Area Office and Headquarters that the "chances are slim" that Lapwai will ever compete successfully for facility replacement. A review of all the facilities which have been completed under the National Facility Replacement Priority System verifies our concern that **small communities will never be served under this system.** The following table presents data provided by the IHS. It shows all the outpatient clinics completed in the last ten years, their location and the size of the community. The average size of communities to receive replacement outpatient clinics under the current system is 15,522 people.

HEALTH CLINICS COMPLETED IN THE LAST TEN YEARS

AREA	FACILITY	YEAR	* APPTD. $	UNIT	SUP.	SAP.
Aberdeen	FtThompson SD	1988	$ 3,449	Crow Creek	4,277	3,799
Aberdeen	Kyle, SD	1989	3,209	Pine Ridge	17,537	20,523
Billings	LodgeGrassMN	1982	1,485	Crow	8,471	7,418
Navajo	InscriptionHs	1983	3,890	Kayenta	14,879	14,463
Navajo	Huerfano NM	1984	3,304	Shiprock	39,437	35,035
Navajo	Tsaile, AZ	1984	3,856	Chinle	25,394	27,013
Phoenix	Cibeque, AZ	1980	750	White River	9,837	10,996
Phoenix	Ft.DuchesneUT (Dzilth Clinic)	1984	2,220	Uintah&Ouray	4,347	2,858

NOTE: The service area population (SAP) is the 1988 total of people in the area who are elegible to receive services of the hospital or clinic; the service unit population (SUP) is the 1988 number of registered users over the past two years.

* AMOUNTS ARE IN THOUSANDS.

Hospital construction has also been targeted at larger communities, although this is more understandable. The communities served by hospitals built under the priority list system seem to be the same communities served by outpatient clinics built under the priority system. Other communities in the Northwest, West, Rockies and East, have been left out of this system.

HOSPITALS COMPLETED IN THE LAST TEN YEARS

AREA	FACILITY	YEAR	* APPTD. $	UNIT	SUP.	SAP.
Aberdeen	Rosebud, SD	1989	$ 20,700	Rosebud	9,253	12,043
Alaska	Bethel, AK	1980	34,100	Yukon-Kosk.	23,773	18,048
Alaska	Kanakanak, AK	1987	16,578	Bristol Bay	8,724	10,240
Bemidji	Red Lake, MN	1981	9,566	Red Lake	4,207	5,026
Billings	Browning, MN	1985	15,086	Blackfeet	8,724	10,240
Nashville	Cherokee, NC	1981	10,341	Cherokee	6,423	7,437
Navajo	Chinle, AZ	1982	19,758	Chinle	25,394	27,013
Navajo	Crownpoint NM	1987	17,734	Crownpoint	13,967	15,363
OK City	Ada, OK	1980	14,374	Ada	20,962	30,478
OK City	Tahlequah, OK	1983	21,334	Tahlequah	31,205	36,085
Phoenix	Sacaton, AZ	1988	15,735	Sacaton	10,910	12,836

The average community size for both hospitals and outpatient clinics completed under the priority system ranges from 14,000 to 16,000 population. The community of Lapwai will have difficulty competing with communities of that size, unless there is a separate system developed for smaller communities. The attached map of the United States shows the geographic distribution of Hospitals Completed, Clinics Completed and those In Progress which were approved for construction through the priority rating system. Clearly, large segments of Indian country are not being served.

A PROPOSAL TO SUPPORT TRIBALLY BUILT FACILITIES

The Nez Perce Tribe has examined the National Priority System enough to know that the Lapwai Clinic will never get replaced under that system. The efforts of the tribe to better the quality of health care to our tribal members should not be held captive by the restrictions of the priority system. The Nez Perce Tribe working in cooperation with the Indian Health Service proposes to plan, design and construct the necessary replacement facility for the Northern Idaho Service Unit. The tribe is willing to utilize its financing to accomplish this project and seeks the support of the Indian Health Service as the primary tenant of the building. The Indian Health Care Amendments of 1988 provided language supportive of such an effort:

Sec. 701.Section 704 (25 U.S.C.1674) is amended...(2) by adding at the end thereof the following new subsection: "(b) The Secretary may enter into leases, contracts, and other legal agreements with Indian tribes or tribal organizations which hold (1) title to; (2) a leasehold interest in; or (3) a beneficial interest in..; facilities used for the administration and delivery of health services by the Service or by programs operated by Indian tribes or tribal organizations for costs associated with the use of such facilities for such purposes. Such costs include rent, depreciation based on the useful life of the building, principal and interest paid or accrued, operation and maintenance expenses, and other expenses determined by regulation to be allowable."

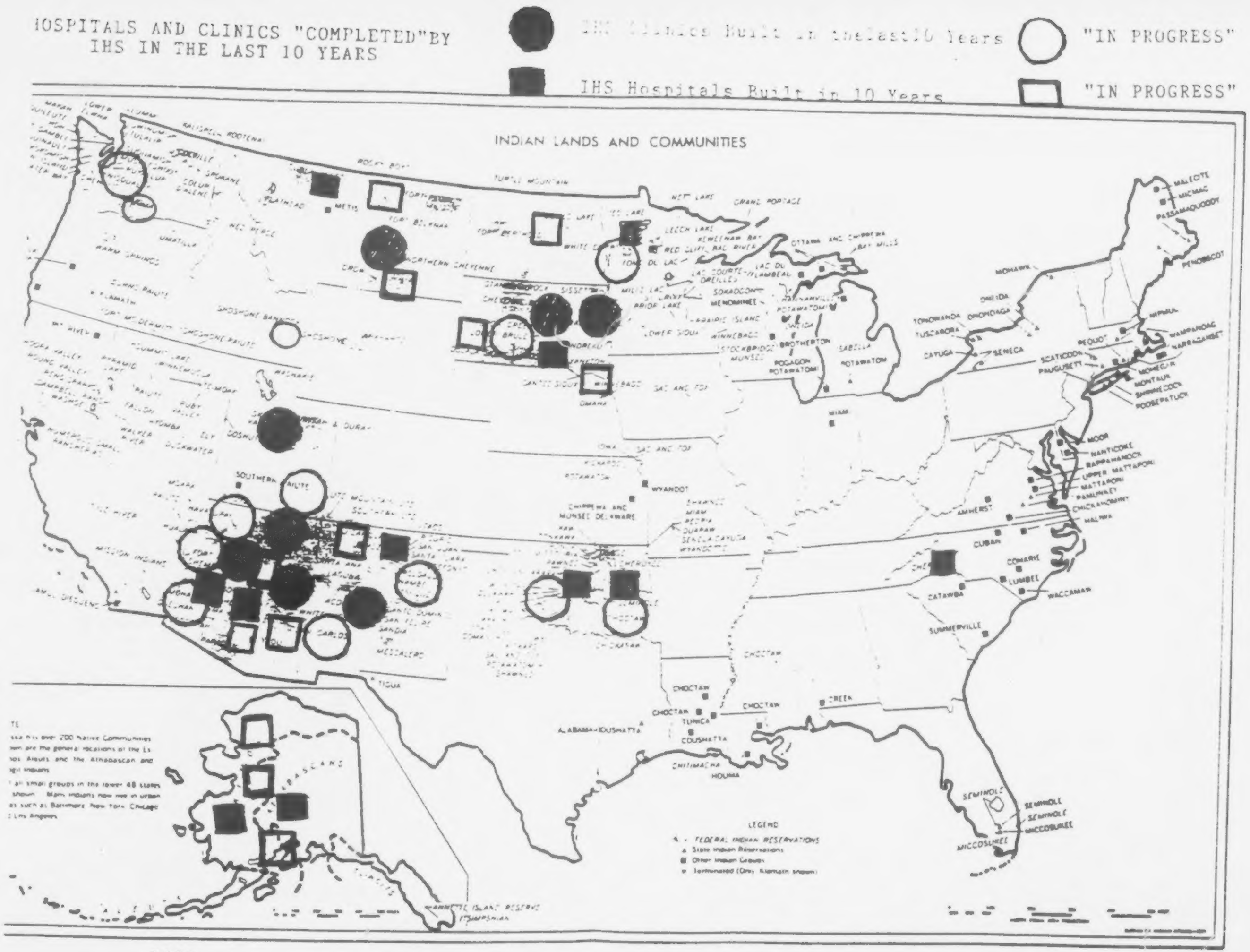
Initial discussions have been held with the Portland Area IHS staff regarding the needed dimensions of a replacement facility at Lapwai. Before exact square footage can be determined and cost estimates put forward, the Nez Perce Tribe and IHS need to assess the patient population and workload data and how it has been negatively impacted by the small and inadequate facility currently housing our health services. It is estimated that the productivity of our two physicians will double, if and when an adequate replacement facility is constructed. The layout of clinic space will provide the privacy needed by patients, and eliminate the dangerous safety hazards of utilizing the basement for patient care. The Tribe is proposing to build the needed facility based on the data from the Indian Health Service and space requirements described by IHS planners. The Nez Perce Tribe will lease space to the Indian Health Service which is used for IHS services. Other space may also be available for tribal health care programs. This will allow for a better coordination of services and improved quality of care for the patient.

The Nez Perce Tribe is looking to this current year for approval to begin planning with the Indian Health Service. By 1991, the site, design and cost estimates will be completed and the Nez Perce Tribe will ask Congress for the approval of lease payments for the space and necessary equipment and staffing increases in FY 1992. It is estimated that the replacement clinic could be completed by early 1992, if Congress approves a joint venture between the Nez Perce Tribe and the Indian Health Service to replace the Lapwai Clinic. Without Congressional support for the Tribes investment, the Indian Health Service will not participate in this project.

The Nez Perce Tribe is committed to delivering a substantial upgrade in health care facilities to our tribal members. We do not want to see our members stay away from health care services because of the dilapidated and overcrowded conditions of the clinic. Our community is not one of the largest Indian communities in the United States. It is one that is willing to invest in our own future. We have the financing to begin the process of replacing our old clinic. We need the cooperation of the Indian Health Service and the support of Congress.

Thank you for this opportunity to provide testimony.

HOSPITALS AND CLINICS "COMPLETED" BY IHS IN THE LAST 10 YEARS


IHS Clinics Built in the last 10 Years
"IN PROGRESS"
IHS Hospitals Built in 10 Years
"IN PROGRESS"
INDIAN LANDS AND COMMUNITIES
LEGEND
FEDERAL INDIAN RESERVATIONS
State Indian Reservations
Other Indian Groups
Terminated (Only Klamath shown)
TURTLE MOUNTAIN
NETT LAKE
GRAND PORTAGE
LEECH LAKE
RED CLIFF
BAD RIVER
LAC DU FLAMBEAU
LAC COURTE OREILLES
SOKAOGON
MENOMINEE
ONEIDA
STOCKBRIDGE MUNSEE
WINNEBAGO
LOWER SIOUX
PRIOR LAKE
OTTAWA AND CHIPPEWA
BAY MILLS
POTAWATOMI
BROTHERTON
SABELLA
POKAGON POTAWATOMI
MIAMI
MOHAWK
ONEIDA
ONONDAGA
TONAWANDA
TUSCARORA
CAYUGA
SENECA
MALECITE
MICMAC
PASSAMAQUODDY
PENOBSCOT
NIPMUC
WAMPANOAG
NARRAGANSETT
PEQUOT
SCATICOOK
PAUGUSETT
MOHEGAN
MONTAUK
SHINNECOCK
POOSEPATUCK
MOOR
NANTICOKE
RAPPAHANNOCK
UPPER MATTAPONI
MATTAPONI
PAMUNKEY
CHICKAHOMINY
NAHWA
AMHERST
CUBAN
COHARIE
LUMBEE
WACCAMAW
CATAWBA
SUMMERVILLE
CHEROKEE
CREEK
CHOCTAW
TUNICA
COUSHATTA
ALABAMA-COUSHATTA
CHITIMACHA
HOUMA
SEMINOLE
MICCOSUKEE
WYANDOT
CHIPPEWA AND MUNSEE DELAWARE
SHAWNEE
MIAMI
PEORIA
QUAPAW
SENECA-CAYUGA
WYANDOTTE
SAC AND FOX
IOWA
KICKAPOO
POTAWATOMI
OMAHA
SANTEE SIOUX
CHICKASAW
ROCKY BOY
FORT BELKNAP
FORT PECK
NORTHERN CHEYENNE
CROW
METIS
FLATHEAD
KALISPEL
KOOTENAI
SPOKANE
COLVILLE
COEUR D'ALENE
NEZ PERCE
UMATILLA
WARM SPRINGS
KLAMATH
SHOSHONE BANNOCK
WIND RIVER
ARAPAHO
WASHAKIE
GOSHUTE
SOUTHERN PAIUTE
UTE MOUNTAIN UTE
SOUTHERN UTE
MISSION INDIANS
SANTO DOMINGO
SAN FELIPE
SANDIA
MESCALERO
TIGUA
SAN CARLOS
PYRAMID LAKE
WALKER RIVER
FALLON
DUCKWATER
ELY
ANNETTE ISLAND RESERVE
TSIMPSHIAN
ATHAPASCANS

1990

Data Source: Indian Health Service Headquarters

STATEMENT OF SENATOR FRANK H. MURKOWSKI
HEARING OF THE SELECT COMMITTEE ON INDIAN AFFAIRS
March 22, 1990

Mr. Chairman, I commend you for calling this hearing on the issue of health facilities in Indian areas. In many areas of the nation, this is a critical problem, and I know that the backlog of unmet needs is very great.

Some of Alaska's most urgent facility needs have worked their way to the top of the priority list -- hospitals in Kotzebue and Anchorage, for instance -- but, as elsewhere, annual appropriations are insufficient to meet all needs.

The Bristol Bay Area Native Health Corporation, which operates the hospital at Kanakanak, has informed me of problems at the hospital requiring expenditures of several millions of dollars just for repair and renovation. Both the personnel quarters and hospital need to have the asbestos removed; fuel oil is seeping into the basements of buildings (with the hospital's storage tanks believed to be the source) and the tanks may need to be replaced; and repairs to roofs, plumbing, and interiors are required. In addition to these near-emergency type needs, the Health Board has identified spending that will be required to improve the provision of health care to the Natives of the Bristol Bay region.

With regard to the Alaska Native Medical Center, a study is being conducted to learn whether an alternative financing plan would be feasible, given the projected cost of the facility. Given that the Medical Center is the major hospital serving about 85,000 Alaska Natives, we are looking forward to the results of that study so that planning for the construction may move ahead.

The study itself has raised concerns among Alaska Natives. The Calista Corporation reports that Indian preference in contracting for the construction of the facility is being rejected by the analysts, and has prepared a statement for this hearing. I ask, Mr. Chairman, that this statement be entered into the record.

Mr. Chairman, I raise these issues, trusting that they do not detract from the focus you have given to today's hearings. In the area of health facilities, as in other areas of Indian programs, Alaska is -- once again -- somewhat different.

Calista Corporation

601 W. 5th Avenue, Suite 200, Anchorage, Alaska 99501-2225 • (907) 279-5516 • FACSIMILE (907) 272-5060

March 15, 1990

The Honorable Daniel K. Inouye, Chairman
The Select Committee on Indian Affairs
United States Senate
838 Hart Bulding
Washington, D.C. 20510

Dear Senator Inouye:

I appreciate this opportunity to address our concerns regarding the Alaska Native Medical Center (ANMC) scheduled to be built in Anchorage, Alaska to the Senate Select Committee on Indian Affairs. Based on a recent study commissioned by the Indian Health Service (IHS) to determine the feasibility of funding the construction of the ANMC utilizing private sector financing, Calista Corporation is concerned that IHS will recommend to Congress that an open market bidding process supplant Indian preference in the contract to be let for the construction of this facility.

Calista Corporation has invested considerable effort and resources to confirm that we, as well as other Native regional corporations, have full access to the financial resources and hospital construction expertise required to construct the ANMC on a timely and cost effective basis. For these reasons:

1. That the facility is for the benefit of Alaska Natives,
2. That Alaska Native corporations are qualified to perform the contract, and
3. That Indian preference in the IHS contract can be implemented at no additional cost to the federal government,

Calista Corporation believes it is important to Alaska Natives and Congress that the principles of Indian preference contracting be adhered to in the construction of this project.

I respectfully request that our written comments be entered into the official record of the Senate Select Committee's March 22, 1990 Hearing on Indian Health Facilities.

Sincerely,

CALISTA CORPORATION
Johnny T. Hawk
Johnny T. Hawk
President & Chief Executive Officer

cc: Senator John McCain

Calista Corporation
601 W. 5th Avenue, Suite 200, Anchorage, Alaska 99501-2225 • (907) 279-5516 • FACSIMILE (907) 272-5060

WRITTEN TESTIMONY
SUBMITTED TO:

THE SENATE SELECT COMMITTEE ON INDIAN AFFAIRS
HEARING ON INDIAN HEALTH FACILITIES
MARCH 22, 1990

Calista Corporation is an Alaska Native regional corporation established in 1972, pursuant to the provisions of the Alaska Native Claims Act (ANCSA) enacted by Congress on December 18, 1971. The Calista region, with more than 58,000 square miles in southwest Alaska, encompasses an area about 20 percent smaller than Oklahoma and 20 percent larger than New York state. With more than 13,000 Yupik Eskimo shareholders, Calista Corporation represents about one-sixth of all Native Americans in Alaska. Calista Corporation is grateful to the Senate Select Committee on Indian Affairs for this opportunity to comment in (formal title of topic).

The proposed Alaska Native Medical Center (ANMC) in Anchorage, Alaska is so clearly a facility for the benefit of Native Americans that one may conclude that the Buy Indian provisions of the Indian Health Care Act (P.L. 94-437) would necessarily govern the Indian Health Service (IHS) in contracting for its construction. This conclusion, apparently, is mistaken.

In September, 1989, IHS let a contract to determine the feasibility of providing for the private financing and construction of the ANMC, and its lease and/or purchase by IHS. The study, which is being conducted by First Chicago Corporation, investigates three methods of providing the hospital as alternatives to the direct appropriation of construction funds by Congress. These alternatives are:

1) Lease Purchase.
2) Lease Purchase with Option to Buy Early.
3) Build To Buy.

However, for each alternative, according to First Chicago's project manager, IHS instructed the consultant to limit the analysis to considering only the open and competitive bidding process. The financial feasibility study specifically does not address Indian preference in its analysis of the options, including direct appropriation.

Lacking IHS' rationale for limiting the study only to the consideration of open market bidding, the agency's future intent regarding letting the contract for the ANMC cannot be known with certainty. However, this action at least suggests that IHS may recommend that Congress exempt the ANMC from the application of Indian preference legislation. Whether this is IHS' intent or not, one effect of the study will surely be a mounting of non-Indian pressure on IHS and Congress to override Indian preference considerations and use the open market process. This pressure will build, in part, because the study contacts major developers and financial institutions and "informs" them that the open and competitive process will be used to award the contract, whatever option is selected.

Calista Corporation appreciates this opportunity to urge members of the United States Select Committee on Indian Affairs to remain steadfast in their commitment to the use of Indian preference in contracts to provide Indian Health Service facilities for the benefit of Alaska Natives. If the ANMC served only one Native region, the ANCSA corporation representing that region would have a preemptive right under P.L. 93-638, Section 103 to obtain a contract to construct the facility, if it has a qualified construction firm, or to obtain the construction contract and award it to a third party. However, the ANMC is the primary hospital not for one, but five Native regions in Alaska and it serves shareholders of all regions because it is located in Anchorage, the state's population center.

Whereas the multi-regional characteristic of the Alaska Native Medical Center's service area negates the authority of any one region to preemptively obtain the construction contract, this is otherwise an incidental feature that should not be allowed by Congress to undermine the intent of Buy Indian legislation or its benefits to Alaska Natives. Calista Corporation suggests to the committee members that the intent of Buy Indian legislation and its benefits to Alaska Natives can be straightforwardly preserved by requiring the Indian Health Service to allow only ANCSA regional corporations to bid on a contract to finance, construct, and own the ANMC to ANCSA regional corporations. Based on our own investigation, we can assure the committee that regional corporations have access to the financial and hospital construction resources to provide IHS with a high quality facility on a timely basis. Moreover, such a process provides for sufficient competition to insure that the fiscal interests of the Federal Government are well served.

Finally, Calista Corporation has a strong interest in participating in the ANMC project, whatever the method of contracting that is ultimately selected. However, we firmly believe the interests of the Federal Government, Native Alaskans, as well as our own are best served if Congress directs that Buy Indian provisions be implemented in IHS contracting for the Alaska Native Medical Center in Anchorage.

PREPARED STATEMENT OF DONOVAN ARCHAMBAULT

The Fort Belknap Tribes are pleased to have the opportunity to submit testimony on an issue of great concern to the Tribe and its members -- the need for new approaches to Indian health facilities.

Over the past 12 months, the Tribe, with assistance from this Committee and IHS, has explored the options and opportunities available for health facilities that better meet the health needs of our tribal members. We are excited by what we have learned. There are some interesting new approaches for health programs and facilities developed in the non-Indian rural health community that may be relevant to the needs of Ft. Belknap and other Indian communities. In particular we are investigating a model called the "rural health facility," which is something less than a full-scale hospital but more than an outpatient clinic, and which, using a swing-bed approach, provides in-patient services for acute care, alcoholism, mental health, convalescent, long term care, etc. Since all of these are areas of major health problems on our reservation, this model could be the most appropriate kind of facility for us and many other tribes. Perhaps most significantly, it appears that such a model could be implemented without significantly increasing the cost of facility construction or of daily operating costs. Since Fort Belknap is presently at the top of the IHS priority list for a new facility, and since Congress has already provided funds for the design of new facilities at Fort

Belknap, we can and are ready to be the first tribe to implement this new approach if it proves to be feasible.

To enable for this model to be explored and tested, we urge the Congress to enact legislation to:

1. establish a demonstration program that would permit tribes and IHS to explore and test the appropriateness of new health facility models and which provides a small amount of money for feasibiltiy studies; and
2. permit IHS to design facilities that will provide long-term nursing care services as one part of its purpose, at least where the day-to-day operation of such services can be financed through third party sources.

A detailed description of our experience and findings on the issue of new approaches to health facilities follows.

Background

Fort Belknap has a 60-year old hospital that has been condemned. We were told by IHS that we no longer had the average daily patient load (ADPL) to support a hospital, such that it would be replaced with a clinic plus three holding beds. While the tribal leaders are not health professionals, we knew that a clinic would not adequately serve our needs, for several reasons. First, it would create serious problems for acute care patients having to travel long distances over dangerous roads during the severe Montana winters to the nearest non-Indian facility. Secondly, that approach would force us to rely on contract care for much of our health services and we know that IHS is so underfunded for contract care that is able to pay only for emergency procedures. Thirdly, we saw that there were many health needs, beyond acute care, that require in-patient care, including alcoholism, mental health problems, convalescent care and long-term nursing care for our growing elderly population. The Tribe was also interested in exploring ways that a reservation facility could serve both Indian and non-Indian patients.

When we asked IHS if there were any alternatives that would be less than a hospital but more than a clinic, we were told the agency was not authorized to even consider any alternatives. At this point, Congress had already appropriated $800,000 for design of the clinic. But recognizing that whatever facility is built would be with us for 60 years, our people refused to proceed with a clinic until every other option was explored. We therefore encouraged this Committee to freeze IHS construction funds until a full study was conducted.

Rural Health Facility Model

We express our appreciation to the Committee for taking this step because it gave us time to do the exploration. Between the time that letter was written and this hearing, the Tribe using its own funds, commissioned a study by Mr. Jim May, the foremost expert in the area of rural health facilities. Mr. May has helped many rural communities that could no longer support an acute care hospital to develop a new and successful approach called the rural health facility model.

Facility Model

That model is described in Mr. May's report to the Tribe which is appended ~~to~~ this report. In capsule form, under that approach the in-patient facility uses the swing-bed concept to serve the full range of in-patient needs -- acute care, alcoholism, mental health, nursing, convalescent, etc. This model has proven to be successful in several key aspects.

1. It works financially. The diverse uses are able to support physicians and other health professionals by spreading the costs around, in ways that a pure acute care facility cannot, because of the third party resources that are available to pay for such non-acute in-patient services.
2. The health professionals like working in such facilities because of the diverse challenges it presents.
3. It offers opportunities to hold down costs through such practices as having itinerant surgeons visit on a regular basis to do non-emergency surgery. For IHS this would substantially reduce the contract care budget and backlog.
4. The cost of constructing such a facility is much less than an equivalent bedded acute care hospital and not much more than a clinic.
5. Such a facility like this would be attractive to, and able to serve, the non-Indian as well as Indian community on and near the reservation.

The Finding at Fort Belknap

Mr. May conducted a very initial review to determine if this model could work at Fort Belknap. His conclusion is that, given the combined Indian and non-Indian population and health needs on the reservation, if this were a non-Indian rural community, it could justify and cash-flow a 40-50 bed facility. He also concluded that such a facility could be built at a price that is close to the amount IHS has identified as the cost of the proposed clinic. We urge the Committee members to read Mr. May's succinct but highly informative report.

The Tribe is excited and encouraged by these initial findings and is now working with IHS to identify funds for an in-depth feasibility study. This is necessary to determine if the rural health facility concept will work on an Indian reservation in light of the unique health financing aspects (IHS funding, the different role Medicaid and Medicare play, etc.), the unknown of whether a non-Indian would utilize an IHS facility, and all of the other unique reservation factors. But if the feasibility study proves the model will work, Fort Belknap wishes to be among the first to implement this model. Since the Tribe is at the top of the IHS facilities priority list and already has design funds appropriated for it, the Tribe is particularly well placed to be the first to proceed.

However, for this to happen, Congress will have to enact legislation to provide IHS and tribes with the necessary authority to proceed. Specifically, the legislation needs to:

1. Provide IHS with the authority to propose to Congress facility construction projects that demonstrate new approaches. Presently, IHS considers itself restricted to proposing that a tribe on the priority list be funded for either a full acute care hospital or for an outpatient clinic, depending on its ADPL. The legislation should authorize IHS to propose other models, such as the rural health facility model, when the tribe has agreed to such an approach and when a feasibility study has shown that such a model makes sense from a medical perspective, will not entail unreasonable construction costs and will not lead to unreasonable operating costs. Congress should also authorize a small appropriations for IHS and the tribe to use to carry out the feasibiity studies.
2. Authorize IHS to include beds for long-term nursing home care in its facility proposals to Congress so long as doing so does not add unreasonable construction costs and so long as the nursing home services will be largely self-supporting through third-party payments. The issue of nursing home care for Indians has been in a no-man's-land for too long. Tribes are told that IHS has no authority to provide such care and that it is BIA's responsibility. But the BIA is given no funding for it. As a result, the Federal government has, by omission, simply abdicated its responsibilty for the growing elderly Indian population. Because of this, the Indian

elderly are too often shipped to nursing homes far from their reservation, where their families cannot visit them and they are separated from the culture and lifestyle that is part and parcel of their very being. Or they are taken care of by their families who lack the adequate housing, income or other resources to provide proper care.

We recognize that IHS has inadequate funds to meet its present service needs and therefore cannot afford to assume new responsibilities for nursing care. But the experience of at least some tribes is that nursing home care can be provided at no cost to IHS if operated by the Tribe using third party resources. The problem is that the existing federal policy that prohibits IHS from having anything to do with nursing care has placed an artificial barrier between IHS medical care and tribally provided nursing home care, e.g., forcing them to be located in separate buildings so that the medical care is not as readily available. This artificial barrier needs to be removed. Even without funds to provide direct nursing care, IHS can and should play a significant role in helping tribes to address the need for such care. In particular, the Tribe requests that Congress authorize IHS to do the following:

1. Provide technical assistance to tribes to help them set-up nursing care service programs.

2. Allow such programs to be functionally integrated into the IHS delivery system.
3. Permit IHS to include nursing home beds in any new IHS facility, where doing so will not significantly add to the cost of construction and where the Tribe will operate a nursing care program at no or little cost to IHS. This will save the federal government money since it will establish a rational and cost effective nursing home program for Indians, as an alternative to the existing situation in which acute care beds are used for nursing care and/or Indians are shipped off to more expensive off-reservation nursing homes.

In conclusion, the Tribe again thanks the Committee for its leadership role in this area and urges the Committee to enact legislation that creates a facilities demonstration program and a rational policy on long-term nursing care for elderly Indians.

May & Associates

(314) 765-5556
Fax (314) 765-3473

Rural Health Systems
Analysis/Design/Management

Rt. 2 Box 539
Richland, MO 65556

PROPOSAL FOR FEASIBILITY STUDY

This request for a feasibility study was developed and is being submitted in response to and as an alternative to the proposal by the Indian Health Service to replace the Fort Belknap Indian Reservation's existing 58 year old hospital with clinic facilities which would no longer provide acute inpatient services to tribal members. The Indian Health Service has estimated the total construction cost of the clinic facilities at approximately 10 million dollars.

The Tribe believes that before an expenditure of this magnitude is committed--with a resulting reduction in the scope of healthcare services provided on the Reservation--a feasibility study should be made to determine the healthcare services the Tribe both needs and can afford. Demographics and geography indicate a broader scope of services than outlined in the Indian Health Service proposal.

A DECADE OF CHANGE IN RURAL HEALTHCARE DELIVERY

The 1980s brought about significant changes in the provision of healthcare services, particularly in rural areas. As the Federal government sought ways to deal with a mounting budget deficit and rapidly increasing healthcare costs, the healthcare industry responded to changing legislation and physician shortages through innovative methods to serve rural healthcare needs in a cost-effective manner.

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Industry Response

The rural healthcare industry has had to respond to the constraints implemented by Medicare, Medicaid, and other third-party payors and to the increasing physician shortages. The providers of healthcare services have followed the intent of the legislative and regulatory changes as well as the changes in the marketplace brought about by increased competition and the diminishing resources available to pay for healthcare services. This shift in the provision of healthcare services has been away from the traditional inpatient acute care setting to less resource intensive methods of meeting the increasing demand for services. Examples of this shift include surgery procedures that were a short while ago considered appropriately provided only as an inpatient service in an acute care hospital which are now routinely or exclusively provided in outpatient settings as one-day outpatient visits or in physicians' private offices; the acceptance of "observation patients" for diagnostic procedures prior to admission to acute care facilities; the establishment of Medicare-certified skilled nursing units in long-term intermediate care facilities to accommodate the increased demand for less resource intensive services due to the increased emphasis placed on shortening the lengths of stay in acute care facilities; and the expansion of the range of services provided by acute care hospitals to both utilize the excess capacity of their facilities and to attempt to minimize the adverse effects of reduced demand and reimbursement for their traditional services.

Rural Healthcare Response

Rural hospitals have historically been the dominant providers of healthcare services in their communities. The dominance has been factual as well as perceptual. Through the rural hospitals' medical staffs the hospitals have enjoyed a unique relationship with the communities' physicians. This relationship has provided the physician with the primary, if not the sole source, of inpatient services for their patients. Communities have come to view their hospitals as a necessary element in their lives, as well as an inherent right, all but guaranteeing their future healthcare needs will be met. As a major employer in the community, rural hospitals have exercised significant influence on the community's economy. These relationships are now changing as more physicians become employees rather than individual practitioners and as rural hospitals have faced financial hardships and closure. The changes brought about in the past decade, due to the allocations of resources, have resulted in the reevaluation of the purpose and mission of rural hospitals. Rural hospitals have expanded the services they offer through expansion of their mission to encompass the provision of specialty services provided through the use of "visiting" physician specialists; physician and physician directed services conversion of acute care beds to long-term beds utilizing "swing-bed" programs to provide skilled nursing services, or the designation of distinct skilled nursing units; ventures to provide intermediate and residential long-term care to their communities; the establishment of hospital-based home health and hospice services; and the expansion and/or renovation of their physical plants to accommodate the increasing demand for services provided in outpatient settings.

The communities that have recognized the healthcare needs of their residents and have matched those needs to the available resources, while recognizing the limitations in their abilities to meet all the healthcare needs which have been historically met, have survived the changes of the past decade with their basic healthcare needs still being provided within their community. Those rural hospitals which have failed to recognize the necessity for change have either unduly limited the healthcare services provided to residents within their community or, in a growing number of instances, have been forced to close.

CHANGES IN DEMAND FOR HEALTHCARE AT FORT BELKNAP INDIAN RESERVATION

These forces of change have also impacted the healthcare delivery system that should be considered for the residents of the Fort Belknap Indian Reservation as supported by the following:

* Although only providing limited services, the Reservation's hospital maintained an average census of 4.9 patients during fiscal 1989. While this census alone is not sufficient to justify the resources necessary to

maintain an acute care hospital, it does nevertheless indicate a significant demand for acute care services for tribal members on the Reservation. Considering over 300 days of acute care hospital services provided to tribal members at other hospitals during fiscal 1989, and the 25 tribal members currently in 7 different long-term care facilities within the State of Montana, there is a potential for increased utilization of an acute care facility on the Reservation with an increase in the services available.

* Geography is the Reservation's limiting and defining element. Tribal members are clustered along the Reservation's northern and southern borders, 60 and 40 percent, respectively--approximately 45 miles apart. This dispersion creates the need to allocate resources to two locations which will by necessity most likely result in the duplication of some services provided.

* Geography further limits the alternatives available for acute care hospital services. The closest acceptable hospital as an alternative for the Reservation's facility is located in Havre. This hospital is from 45 to 98 miles from the Reservation's residents. With the severe weather conditions during the long winter months, the Havre hospital may not be an acceptable alternative to providing acute care hospital services on the Reservation.

* The potential for providing long-term care on the Reservation should be evaluated. With over 150 tribal members age 65 and over residing on the Reservation indicating a need for 7 to 9 long-term beds, 25 tribal members currently in long-term facilities off the Reservation, over 150 tribal members age 55 to 65 residing on the Reservation, and the potential for sharing resources of an acute care facility, it appears a long-term care facility warrants evaluation. For older tribal members, particularly those who have survived their immediate family, the Tribe is the extended family. Dislocation from the Tribe and being placed in nursing homes off the Reservation with a different cultural environment exerts an undue hardship on those elders needing long-term care. This evaluation should include a range of potential services from skilled nursing to supervised residential care and include alternatives such as swing-beds and homemaker support services.

* The potential need for providing speciality inpatient services on the Reservation including alcohol and drug abuse detoxification and treatment, mental health treatment, and rehabilitation and convalescence care, should be evaluated. This evaluation should include both long and short-term care as well as determining the need for providing secure accommodations for suicidal or violent patients.

* Over the years, the Reservation has lost services that were once provided to tribal members at its facility. Services were discontinued when the Reservation's facilities were no longer able to maintain the technology or the trained personnel or it became uneconomical. These lost services should be reevaluated. Examples would be obstetrical/newborn and surgical services. Although it may not be reasonable to return to the prior level of services provided, reduced levels, such as a birthing center and minor surgical procedures warrant evaluation.

* The lack of an adequate transportation system--both for emergencies and the nonemergency transportation of patients--increases the demand to provide services on the Reservation rather than to seek outside alternative sources.

  Alternative sources of healthcare off the Reservation become acceptable only when there is an adequate transportation system available and it is perceived as both reliable and enduring.

* The long-term viability of the allocation of resources to meet the healthcare needs of the tribal members must include the evaluation of offering services to nontribal members, who face the same lack of services as tribal members. This may prove to increase both the level and range of services that can be provided due to the econo-

mies which may be achieved. There are 2,800 non-Indians living on the Reservation and in the adjacent communities of Harlem, Savoy, Dodson, Landusky, and Zortman and 3,300 tribal members.

RECOMMENDATIONS FOR FEASIBILITY STUDY

There appears to be sufficient population, given the geography and population demographics, to support a healthcare system consisting of a 40-50 bed facility for acute and long-term care and a comprehensive primary care system with clinics at Fort Belknap Agency and Hays. Our conclusion is based on healthcare demands and utilization expectation of similar populations in similar rural settings. That premise, however, is based on the appropriateness of the healthcare plan, the vision and design of the healthcare system for implementation and maintenance of that Plan, the appropriateness of the physical plants, and the commitment of the population for utilization.

The premise is also based on the presumption that the local healthcare plan and system would be less expensive than transportation and purchased services and that the physical plants for both locations can be constructed for the amount budgeted.

A complete Feasibility Study will be required to:

1. Establish the need and demand for healthcare services on Fort Belknap Reservation from Indian and non-Indian residents.

2. Define a healthcare plan which would, at a minimum, encompass:

    a. Primary care services--on site.
       Emergent and immediate care services.
       Acute episodic, chronic, and preventive care services.
       Mental health services: family and personal counseling and drug and alcohol abuse.
       Health education, home health, and homemaker services.

    b. Primary care services--on site, referral or under agreement.
        Specialty physician services.
        Pharmacy services.
        Preventive and restorative dental services.

    c. Hospital services--acute care nursing and ancillary services.

    d. Long-term care services: skilled, intermediate, and residential.

3. Prepare an architectural assessment of the cost for physical plants necessary to house the healthcare plan as developed.

4. Compute and analyze the short-term and long-term comparative cost of operating the healthcare plan developed.

5. Compare healthcare impact for Indian population.

The performance of the Feasibility Study and the development of the healthcare plan will be less than $100,000.

SUMMARY

The healthcare industry has experienced numerous changes in the past decade. More changes are likely in the future as the Federal government and other third-party payors attempt to deal with the problem of providing adequate healthcare services to an aging population in an inflationary environment. Fort Belknap Indian Reservation must also find a way to provide adequate healthcare services to the residents of the area, given limited financial resources. As the decisions made will affect the Reservation for years to come, it would be prudent to evaluate the alternatives available to the Reservation, including the proposal prepared by the Indian Health Service, to ensure that the residents of the area will have continued access to quality healthcare services in the future.

LISTING OF SUPPORTING DOCUMENTS

- Billings Area Indian Health Service Public Health Nursing Workload Status for Fiscal Year 1989.
- Billings Area Indian Health Services Workload Report for Fiscal Year 1989.
- Billings Area Population Distribution by Age: Fort Belknap: Fiscal Year 1989
- Outpatient Workload by Fiscal Year by Facility: Billings Area Fiscal Year 1980 - Fiscal Year 1989 (ten-year workload)
- Inpatient Discharges and Days: Direct and Contract: 1989 - 1986
- Leading Causes of Inpatient Care - Direct Care: Service Unit Harlem (1988 - 1986)
- Leading Causes of Inpatient Care - Contract Care: Service Unit Harlem (1988 - 1986)
- Providers of Service Fort Belknap Service Unit (1989)

T. Welknaps
cdp
Caryl Lucket

January 3, 1990

Refer to: NRS

Area Nurse Program Officer
Billings Area Indian Health Service

Public Health Nursing Workload Status for Fiscal Year 1989

Associate Director, Office of Health Programs
Rockville, Maryland
Attention: Director, Division of Nursing, Room 6A-44

Attached are the Billings Area Indian Health Service Public Health Nursing Workload Statistics for Fiscal Year 1989. A complete narrative report will be forthcoming.

/s/ Rita M. Harding

Rita M. Harding, R.N., M.N., C.N.A.

Attachments

cc: Director, Billings Area IHS
Deputy Director, Division of Nursing, IHS, Rockville, MD
All Service Unit Directors
All Directors of Public Health Nursing
Tribal Health Director, Flathead Tribal Health Department,
St. Ignatius, MT
Tribal Health Director, Fort Belknap Tribal Health Department, Harlem, MT
Tribal Health Director, Fort Peck Tribal Health Department, Poplar, MT
Tribal Health Director, Northern Cheyenne Tribal Health Department,
Lame Deer, MT
Assistant Area Director, Health Care Branch, Billings Area IHS

BILLINGS AREA INDIAN HEALTH SERVICE PUBLIC HEALTH NURSING PROGRAM
STATISTICAL ANALYSIS OF WORKLOAD FOR FISCAL YEAR 1989

Program Workload and Staffing	Blackfeet	Crow	Flathead	Fort Belknap	Fort Peck	Northern Cheyenne	Rocky Boy's	Wind River	Billings Area
WORKLOAD:									
Total # of Patients	3,417	4,592	5,899	2,005	3,982	2,088	1,261	4,434	27,678
Total # of Patient Encounters	4,409	6,741	12,520	2,542	5,734	3,696	1,645	8,025	45,312
STAFFING:									
Total # of Public Health Nurse Positions (Allocated)	5	4.6	5	2	4	3	2	5	30.6
Total # of Public Health Nurse Positions Filled	2.8	4.2	4.8	1.6	2.9	2.3	1.6	4.8	25.0
PRODUCTIVITY:									
Average Annual Productivity (Visits) per Filled Nurse Position	1,575	1,605	2,608	1,589	1,977	1,607	1,028	1,672	1,812
STAFFING TO POPULATION:									
Service Population	8,950	8,681	7,043	3,281	6,483	4,354	3,230	5,962	47,984
Population per Filled Nurse Position	3,196	2,067	1,467	2,051	2,356	1,893	2,019	1,242	1,919
Population per Allocated Nurse Position	1,790	1,887	1,409	1,641	1,621	1,451	1,615	1,192	1,568

BILLINGS AREA INDIAN HEALTH SERVICE PUBLIC HEALTH NURSING PROGRAM
STATISTICAL ANALYSIS OF WORKLOAD FOR FISCAL YEAR 1989

Program Workload By Age	Blackfeet	Crow	Flathead	Fort Belknap	Fort Peck	Northern Cheyenne	Rocky Boy's	Wind River	Billings Area
Under 1	1,080 (24%)	587 (9%)	1,593 (13%)	134 (5%)	931 (16%)	552 (15%)	207 (13%)	1,240 (15%)	6,324 (14%)
1 to 4	1,102 (25%)	540 (8%)	2,368 (19%)	371 (15%)	1,624 (28%)	685 (18%)	287 (17%)	830 (10%)	7,807 (17%)
5 to 14	406 (9%)	1,934 (29%)	1,154 (9%)	919 (36%)	795 (14%)	320 (8%)	242 (15%)	443 (6%)	6,213 (14%)
15 to 19	341 (8%)	851 (13%)	746 (6%)	292 (12%)	451 (8%)	218 (6%)	123 (7%)	642 (8%)	3,664 (8%)
20 to 44	821 (19%)	1,804 (27%)	2,357 (19%)	317 (13%)	1,289 (23%)	801 (22%)	349 (21%)	2,568 (32%)	10,306 (23%)
45 to 64	300 (7%)	577 (8%)	2,120 (17%)	174 (6%)	338 (6%)	555 (15%)	256 (16%)	1,168 (15%)	5,488 (12%)
over 65	309 (7%)	363 (5%)	2,149 (17%)	332 (13%)	247 (4%)	505 (14%)	178 (11%)	1,029 (13%)	5,112 (11%)
Unknown	50 (1%)	85 (1%)	33 (0%)	3 (0%)	59 (1%)	60 (2%)	3 (0%)	105 (1%)	398 (1%)
TOTAL	4,409	6,741	12,520	2,542	5,734	3,696	1,645	8,025	45,312

BILLINGS AREA INDIAN HEALTH SERVICE PUBLIC HEALTH NURSING PROGRAM
STATISTICAL ANALYSIS OF WORKLOAD FOR FISCAL YEAR 1989

Program Workload By Disease Category	Blackfeet	Crow	Flathead	Fort Belknap	Fort Peck	Northern Cheyenne	Rocky Boy's	Wind River	Billings Area
Communicable Disease	215 (5%)	141 (2%)	101 (1%)	20 (1%)	258 (5%)	74 (2%)	26 (2%)	123 (1%)	958 (2%)
Morbidity	694 (16%)	737 (11%)	2,402 (19%)	153 (6%)	817 (14%)	669 (18%)	171 (10%)	1,682 (21%)	7,325 (16%)
Maternal Child	359 (8%)	668 (10%)	647 (5%)	43 (2%)	312 (5%)	169 (5%)	74 (5%)	1,226 (15%)	3,498 (8%)
School	1,169 (27%)	88 (1%)	331 (3%)	310 (12%)	410 (7%)	195 (5%)	86 (5%)	153 (2%)	2,742 (6%)
Mental	84 (2%)	49 (1%)	151 (1%)	31 (1%)	63 (1%)	88 (2%)	34 (2%)	155 (2%)	655 (1%)
Socio Economic	174 (4%)	2,292 (34%)	710 (6%)	230 (9%)	781 (14%)	806 (22%)	384 (23%)	1,291 (16%)	6,668 (15%)
Health Supervision	1,417 (32%)	1,885 (28%)	6,294 (50%)	1,321 (52%)	2,300 (40%)	1,048 (28%)	671 (41%)	2,618 (33%)	17,554 (39%)
Other	297 (6%)	881 (13%)	1,884 (15%)	434 (17%)	793 (14%)	647 (18%)	199 (12%)	777 (10%)	5,912 (13%)
TOTAL	4,409	6,741	12,520	2,542	5,734	3,696	1,645	8,025	45,312

BILLINGS AREA INDIAN HEALTH SERVICE PUBLIC HEALTH NURSING PROGRAM
STATISTICAL ANALYSIS OF WORKLOAD FOR FISCAL YEAR 1989

Program Workload In Selected Areas	Blackfeet	Crow	Flathead	Fort Belknap	Fort Peck	Northern Cheyenne	Rocky Boy's	Wind River	Billings Area
Prenatal/Postpartum	323	476	589	43	303	162	73	1,022	2,991
Newborn/Well Child	149	311	949	27	176	215	16	328	2,171
Family Planning	26	0	105	5	38	41	0	98	313
Immunization/ Preventive Health	1,265	858	1,024	679	646	403	371	1,377	8,613
Communicable Disease	68	97	35	8	264	95	91	329	987
Diabetes	38	102	1,338	14	164	332	28	973	2,989

BILLINGS AREA INDIAN HEALTH SERVICE PUBLIC HEALTH NURSING PROGRAM
STATISTICAL ANALYSIS OF WORKLOAD FOR FISCAL YEAR 1989

Program Workload By Place of Service	Blackfeet	Crow	Flathead	Fort Belknap	Fort Peck	Northern Cheyenne	Rocky Boy's	Wind River	Billings Area
Total # of Home Visits	1,234 (28%)	1,348 (20%)	3,881 (31%)	331 (13%)	2,695 (47%)	1,589 (43%)	658 (40%)	3,290 (41%)	15,026 (33%)
Total # of Clinic (Facility) Visits	1,367 (31%)	1,887 (28%)	125 (1%)	610 (24%)	459 (8%)	813 (22%)	99 (6%)	1,766 (22%)	7,126 (16%)
Total # of School Visits	0 (0%)	2,090 (31%)	1,628 (13%)	686 (27%)	516 (9%)	148 (4%)	263 (16%)	241 (3%)	5,572 (12%)
Total # of Office Visits	1,543 (35%)	135 (2%)	2,629 (21%)	356 (14%)	1,089 (19%)	998 (27%)	197 (12%)	1,765 (22%)	8,712 (19%)
Total # of Other Visits/Services	265 (6%)	1,281 (19%)	4,257 (34%)	559 (22%)	975 (17%)	148 (4%)	428 (26%)	963 (12%)	8,876 (20%)
TOTAL	4,409	6,741	12,520	2,542	5,734	3,696	1,645	8,025	45,312

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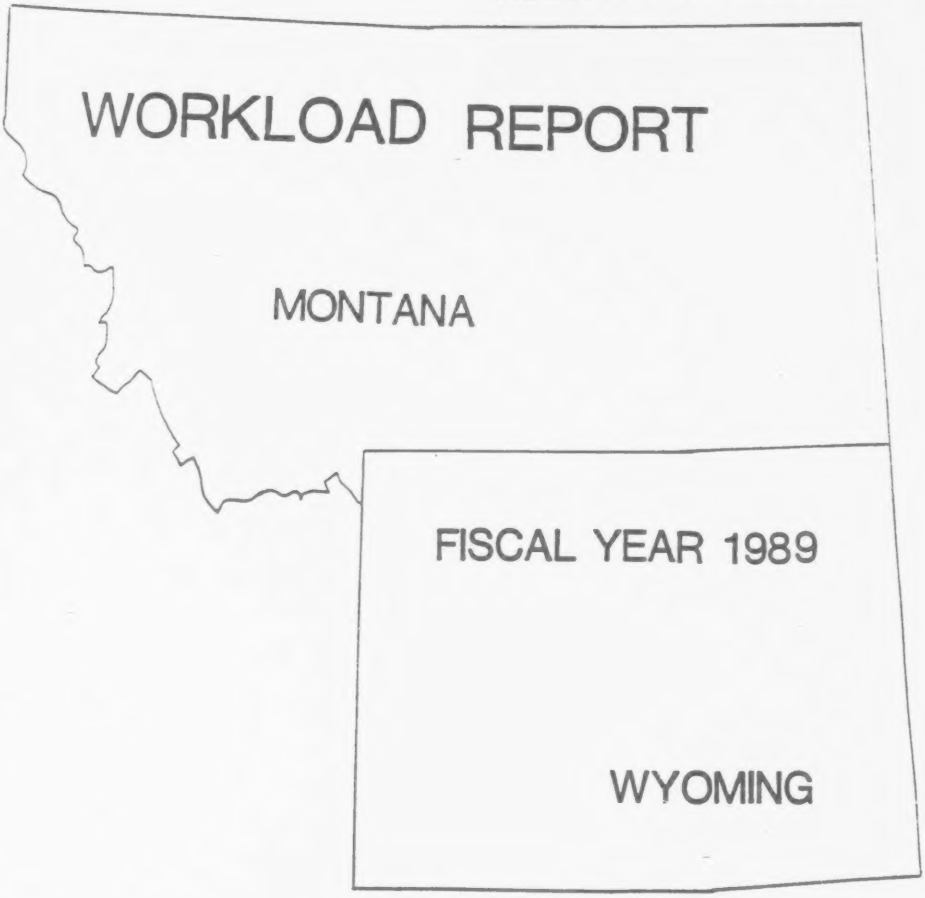
BILLINGS AREA

INDIAN HEALTH SERVICE



WORKLOAD REPORT

FISCAL YEAR 1989

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS)
PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE
BILLINGS, MONTANA

TABLE 1
INPATIENT/OUTPATIENT WORKLOAD
Fiscal Year 1988 and 1989
Billings Area

HOSPITAL HEALTH	Fiscal Year 1989	Fiscal Year 1988	Percent Change FY89/FY88
Adult and Pediatric ADPL	30.8	31.5	-2.2
Adult and Pediatric Admissions	3,487	3,652	-4.5
Adult and Pediatric Hospital Days	11,245	11,503	-2.2
Newborn ADPL	2.5	2.3	+8.7
Newborn Admissions	396	387	+2.3
Newborn Hospital Days	910	827	+10.0
Total Outpatient Visits	127,741	139,045	-8.1
FIELD HEALTH			
Health Centers and Health Stations Total Outpatient Visits	203,009	225,257	-9.9
Health Locations, Schools, Etc. Total Outpatient Visits	1,654	4,006	-58.7

TABLE 1 (Con't)

FACILITY	Fiscal Year 1989	Fiscal Year 1988	Percent Change FY89/FY88
BLACKFEET SERVICE UNIT (62,329*)			
Browning PHS Indian Hospital			
Adult and Pediatric ADPL	12.3	15.2	-19.1
Adult and Pediatric Admissions	1,507	1,817	-17.1
Adult and Pediatric Hospital Days	4,473	5,557	-19.5
Newborn ADPL	1.5	1.4	+7.1
Newborn Admissions	218	214	+1.8
Newborn Hospital Days	534	495	+7.9
Total Outpatient Visits	61,383	71,564	-14.2
Heart Butte Health Station			
Outpatient Visits	945	1,990	-52.5
Health Location-Outpatient Visits			
Babb Health Location	-	-	-
Blackfeet Reservation	1	-	-
CROW SERVICE UNIT (63,533*)			
Crow PHS Indian Hospital			
Adult and Pediatric ADPL	13.6	11.9	+14.3
Adult and Pediatric Admissions	1,414	1,407	+0.4
Adult and Pediatric Hospital Days	4,968	4,366	+13.8
Newborn ADPL	1.0	0.9	+11.1
Newborn Admissions	175	168	+4.2
Newborn Hospital Days	371	322	+15.2
Total Outpatient Visits	43,610	42,823	+1.8
Lodge Grass Health Center			
Outpatient Visits	14,077	14,925	-5.7
Pryor Health Station			
Outpatient Visits	5,846	5,509	+6.1

*Total Outpatient Visits for Service Units.

TABLE 1 (Con't)

FACILITY	Fiscal Year 1989	Fiscal Year 1988	Percent Change FY89/FY88
FLATHEAD SERVICE UNIT (9,146*)			
St. Ignatius Health Center			
Outpatient Visits	9,125	6,429	+41.9
Polson Health Center			
Outpatient Visits	21	-	-
FORT BELKNAP SERVICE UNIT (26,012*)			
Fort Belknap PHS Indian Hospital			
Adult and Pediatric ADPL	4.9	4.3	+13.9
Adult and Pediatric Admissions	566	428	+32.2
Adult and Pediatric Hospital Days	1,804	1,580	+14.2
Newborn ADPL	-	-	-
Newborn Admissions	3	5	-40.0
Newborn Hospital Days	5	10	-50.0
Total Outpatient Days	22,748	24,658	-7.7
Hays Health Station			
Outpatient Visits	3,264	2,891	+12.9
FORT PECK SERVICE UNIT (56,839*)			
Poplar PHS Indian Health Center			
Outpatient Visits	36,589	45,633	-19.8
Wolf Point PHS Indian Health Center			
Outpatient Visits	18,599	22,702	-18.1
Health Location-Outpatient Visits			
Poplar Community Hospital	1,267**	3,573	-64.5
Trinity Hospital (Wolf Point)	380**	422	-9.9
Fort Peck Reservation	4	9	-55.5

*Total Outpatient Visits for Service Units.

**PCC Outpatient Report: Poplar Community Hospital/Trinity Hospital Visits: 2,856 Albuquerque Data Center did not accept facility codes, correct workload was not reported.

TABLE 1 (Con't)

FACILITY	Fiscal Year 1989	Fiscal Year 1988	Percent Change FY89/FY88
WIND RIVER SERVICE UNIT (61,073*)			
Fort Washakie PHS Indian Health Center			
Outpatient Visits	33,998	33,908	-0.3
Arapahoe PHS Indian Health Center			
Outpatient Visits	27,075	30,778	-12.0
NORTHERN CHEYENNE SERVICE UNIT (35,113*)			
Lame Deer PHS Indian Health Center			
Outpatient Visits	35,111	36,126	-2.8
Health Location-Outpatient Visits Northern Cheyenne Reservation	2	-	-
ROCKY BOY'S SERVICE UNIT (18,359*)			
Chippewa-Cree Health Center			
Outpatient Visits	18,359	24,366	-24.7
TOTAL OUTPATIENT VISITS-BILLINGS AREA	332,404	368,308	-9.7

*Total Outpatient Visits for Service Units.

Primary Care Provider* Visits
Service Units and Billings Area Total
Fiscal Year 1989

Service Unit	Total Outpatient Visits	Total Primary Care Visits	% of Total Outpatient Visits
Blackfeet Service Unit	62,329	39,901	64.0
Crow Service Unit	63,533	41,712	65.7
Flathead Service Unit	9,146	12	0.1
Fort Belknap Service Unit	26,012	15,425	59.3
Fort Peck Service Unit	56,839	25,847	45.5
Wind River Service Unit	61,073	24,604	40.3
Northern Cheyenne Service Unit	35,113	30,295	86.3
Rocky Boy's Service Unit	18,359	8,677	47.3
BILLINGS AREA TOTAL	332,404	186,473	56.1

*A Primary Care Provider is defined to include the following Ambulatory Patient (APC) System provider types: M.D., Physician Assistant, Pediatric Nurse Practitioner, Nurse Midwife, Contract Physician, Nurse Practitioner, Contract OB/GYN, Tribal Physician, Podiatrist, and Contract Podiatrist.

ANNUAL I [illegible] TOTALS
FISCAL YEAR 1989
BILLINGS AREA

	ANNUAL TOTALS	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.
	ADULT AND PEDIATRIC INPATIENT DAYS												
Total Area	11,245	1,080	957	940	1,018	856	942	957	1,012	888	865	826	904
Browning	4,473	465	396	321	440	365	370	386	425	357	309	318	321
Crow Agency	4,968	462	413	500	465	357	383	413	414	397	385	314	465
Harlem	1,804	153	148	119	113	134	189	158	173	134	171	194	118
	ADULT AND PEDIATRIC ADMISSIONS												
Total Area	3,487	302	290	289	329	277	266	300	302	292	274	272	294
Browning	1,507	129	124	106	137	123	120	125	130	139	120	121	133
Crow Agency	1,414	131	124	141	142	102	97	124	118	107	108	100	120
Harlem	566	42	42	42	50	52	49	51	54	46	46	51	41
	NEWBORN INPATIENT DAYS												
Total Area	910	69	72	60	82	55	63	35	60	88	90	142	94
Browning	534	37	56	30	48	32	45	16	38	53	68	83	28
Crow Agency	371	30	16	30	34	21	18	18	22	35	22	59	66
Harlem	5	2	0	0	0	2	0	1	0	0	0	0	0
	NEWBORN ADMISSIONS												
Total Area	396	37	32	27	35	25	29	21	28	40	31	48	43
Browning	218	18	23	13	19	16	19	11	17	21	21	24	16
Crow Agency	175	18	9	14	16	8	10	9	11	19	10	24	27
Harlem	3	1	0	0	0	1	0	1	0	0	0	0	0

ADULT AND PEDIATRIC A.D.P.L.
FISCAL YEAR 1989
BILLINGS AREA

	ANNUAL TOTALS	OCT	NOV	DEC.	JAN.	FEB.	MAR.	APR.	MAY	JUNE	JULY	AUG.	SEPT.
ADULT & PEDIATRIC A.D.P.L.													
Total Area	30.8	34.8	31.9	30.3	32.8	30.5	30.4	31.9	32.6	29.6	27.9	26.6	30.1
Browning Hospital	12.3	15.0	13.2	10.4	14.2	13.0	11.9	12.9	13.7	11.9	9.9	10.3	10.7
Crow Hospital	13.6	14.9	13.8	16.1	15.0	12.8	12.4	13.8	13.4	13.2	12.4	10.1	15.5
Harlem Hospital	4.9	4.9	4.9	3.8	3.6	4.8	6.1	5.3	5.6	4.5	5.5	6.3	3.9
NEWBORN A.D.P.L.													
Total Area	2.5	2.2	2.4	1.9	2.6	1.9	2.0	1.2	1.9	2.9	2.9	4.6	3.1
Browning Hospital	1.5	1.2	1.9	0.8	1.5	1.1	1.5	0.5	1.2	1.8	2.2	2.7	0.9
Crow Hospital	1.0	0.9	0.5	0.9	1.1	0.8	0.6	0.6	0.7	1.2	0.7	1.9	2.2
Harlem Hospital*	-	-	-	-	-	0.1	-	-	-	-	-	-	-

*As of October 1985, the Fort Belknap (Harlem) PHS Indian Hosital no longer provided obstetrical services; i.e., deliveries - OB patients were transferred to contract care facilities.

BILLINGS AREA POPULATION DISTRIBUTION BY AGE

SERVICE UNIT: FORT BELKNAP YEAR F.Y.1989 STATE MONTANA

TOTAL POPULATION * 3281

INDEX	AGE GROUP	MALE		FEMALE		TOTAL	
		%	#	%	#	%	#
1	UNDER 5 YEARS	6.547	215	6.520	214	13.067	429
2	5 TO 9 YEARS	5.989	196	5.667	186	11.656	382
3	10 TO 14 YEARS	5.790	190	5.790	190	11.580	380
4	15 TO 19 YEARS	6.563	215	6.190	203	12.753	418
5	20 TO 24 YEARS	4.983	163	5.297	174	10.280	337
6	25 TO 29 YEARS	4.076	134	4.398	144	8.474	278
7	30 TO 34 YEARS	3.316	109	3.485	114	6.801	223
8	35 TO 39 YEARS	2.474	81	2.552	84	5.026	165
9	40 TO 44 YEARS	2.157	71	2.334	77	4.491	147
10	45 TO 49 YEARS	1.645	54	1.900	62	3.545	116
11	50 TO 54 YEARS	1.465	48	1.537	50	3.002	98
12	55 TO 59 YEARS	1.272	42	1.242	41	2.514	82
13	60 TO 64 YEARS	1.036	34	1.114	37	2.150	71
14	65 TO 69 YEARS	0.923	30	0.950	31	1.873	61
15	70 TO 74 YEARS	0.542	18	0.590	19	1.132	37
16	75 TO 79 YEARS	0.389	13	0.416	14	0.805	26
17	80 TO 84 YEARS	0.207	7	0.301	10	0.508	17
18	85 YEARS AND OVE	0.126	4	0.220	7	0.346	11
TOTAL		49.500	1624	50.503	1657	100.003	3281

*PERCENTAGES MAY NOT ADD TO THE TOTAL DUE TO ROUNDING.

OUTPATIENT WORKLOAD BY FISCAL YEAR BY FACILITY
BILLINGS AREA
FY 1980 - FY 1989 (10 Year Workload)

	F.Y. 1980	F.Y. 1981	F.Y. 1982	F.Y. 1983	F.Y. 1984	F.Y. 1985	F.Y. 1986	F.Y. 1987	F.Y. 1988	F.Y. 1989
BILLINGS AREA TOTAL	234,584	255,555	247,156	256,112	270,384	293,202	307,824	343,234	368,308	332,404
BLACKFEET SERVICE UNIT TOTAL	48,483	50,120	46,913	47,081	49,634	55,815	61,606	68,403	73,554	62,329
Browning PHS Ind. Hospital	45,548	46,747	43,155	44,214	46,466	52,891	57,649	64,416	71,564	61,383
Heart Butte Health Station	2,462	2,885	2,330	1,830	1,937	1,802	2,424	2,546	1,990	945
Babb Health Location	428	469	483	625	645	605	764	696	-	-
Blackfeet Reservation	45	19	945	412	586	517	769	745	-	1
CROW SERVICE UNIT TOTAL	35,917	39,197	38,011	44,821	49,377	51,924	54,541	63,948	63,257	63,533
Crow PHS Indian Hospital	33,382	36,175	34,148	32,737	33,996	34,130	35,813	43,065	42,823	43,610
Lodge Grass Health Center	-	-	514	9,846	12,201	13,770	14,331	15,156	14,925	14,077
Pryor Health Station	2,401	2,645	2,887	2,164	3,148	3,893	4,366	5,715	5,509	5,846
Crow Reservation	134	377	462	74	32	131	31	12	-	-
FLATHEAD SERVICE UNIT TOTAL	1,449	859	1,570	1,466	1,844	3,422	3,297	3,897	6,431	9,146
St. Ignatius Health Center	1,375	26	69	2	468	2,937	3,121	3,730	6,429	9,125
Flathead Reservation	74	833	1,501	1,464	1,376	485	176	167	2	-
Polson Health Center	-	-	-	-	-	-	-	-	-	21
FT. BELKNAP SERVICE UNIT TOTAL	22,944	25,633	25,310	22,881	23,563	23,889	25,399	25,821	27,549	26,012
Ft. Belknap PHS Ind. Hosp.	20,273	22,326	21,440	19,956	20,404	20,180	21,826	23,422	24,658	22,748
Hays Health Station	2,666	3,307	3,870	2,919	3,157	3,470	3,325	2,393	2,891	3,264
Ft. Belknap Reservation	-	-	[illegible]	2	239	248	6	-	-	-
FT. PECK SERVICE UNIT TOTAL	42,066	47,883	46,664	45,928	47,753	52,235	58,022	64,861	72,339	56,839
Verne E. Gibbs Health Center	28,034	30,575	30,602	31,210	31,380	34,556	37,550	41,427	45,633	36,589
Wolf Point Health Center	13,324	16,426	16,056	14,426	15,906	16,257	17,856	19,240	22,702	18,599
Poplar Community Hospital	-	871	-	281	130	1,222	2,389	2,153	3,573	1,267
Trinity Hospital Wolf Point	-	-	-	241	139	104	1,862	-	422	380
Ft. Peck Reservation	708	11	6	11	96	61	123	179	9	4
WIND RIVER SERVICE UNIT TOTAL	43,440	47,183	47,348	48,171	49,786	51,123	50,692	52,162	64,686	61,073
Ft. Washakie Health Center	26,206	29,027	28,029	27,658	29,313	29,807	30,331	29,186	33,908	33,998
Araphoe Health Center	17,175	18,115	19,024	20,141	20,060	20,812	20,099	22,476	30,778	27,075
Wind River Reservation	59	41	295	372	413	504	262	500	-	-
NORTHERN CHEYENNE S.U. TOTAL	24,440	26,908	25,969	29,022	31,139	36,085	34,661	42,068	36,126	35,113
Lame Deer Health Center	24,440	26,648	25,942	28,814	31,062	36,055	34,273	41,657	36,126	35,111
N. Cheyenne Reservation	-	260	27	208	77	30	388	411	-	2
ROCKY BOY'S SERVICE UNIT TOTAL	15,845	17,772	15,371	16,742	17,288	18,709	19,606	22,074	24,366	18,359
Chippewa-Cree Health Center	15,409	17,771	15,370	16,662	16,821	18,477	19,312	22,074	24,366	18,359
Rocky Boy's Reservation	436	1	1	80	467	232	294	-	-	-

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INPATIENT DISCHARGES AND DAYS
DIRECT AND CONTRACT*
1989-1986

Service Unit	1989				1988				1987				1986			
	DIRECT		CONTRACT		DIRECT		CONTRACT		DIRECT		CONTRACT		DIRECT		CONTRACT	
	Days	Disch.	Days	Disch.	Days	Disch.	Days	Disch.	Days	Disch.	Days	Disch.	Days	Disch.	Days	Disch.
Blackfeet	4,473	1,507			6,038	1,806	1,051	246	7,358	1,859	2,087	397	5,198	1,563	1,385	340
Crow	4,968	1,414			4,366	1,407	1,218	236	4,509	1,402	1,134	255	4,601	1,308	1,306	255
Fort Belknap	1,804	566			1,580	428	642	152	1,721	470	696	165	1,823	447	793	199
Flathead							1,959	569			2,904	743			3,192	779
Fort Peck							2,866	807			4,508	1,103			5,402	1,075
Northern Cheyenne							869	187			879	208			1,132	217
Rocky Boy							916	231			964	289			852	241
Wind River							3,768	1,096			3,867	1,111			4,380	1,056

Source: Direct 2.C
Contract 3.I

*Data for 1989 Contract Care will not be available until January or February 1990.

LEADING CAUSES OF INPATIENT CARE - Direct Care

SERVICE UNIT Harlem

	1989		1988		1987		1986	
	Days	Disch	Days	Disch.	Days	Disch.	Days	Disch.
TOTAL			1,542	419	1999	546	1874	442
Pregnancy, Childbirth and the Puerperium			8	5	46	22	50	20
Accidents, Poisoning and Violence			169	50	264	76	140	60
Diseases of the Respiratory System			253	78	287	72	444	81
Diseases of Digestive System			160	43	147	43	179	37
Mental Disorders			172	55	198	71	108	44
Symptoms and Ill-defined Conditions			144	44	160	70	192	58
Supplemental Conditions			32	18	36	13	42	8
Diseases of Circulatory System			208	44	251	55	167	35
Diseases of Genitourinary System			38	14	131	30	79	20
Diseases of Nervous System			46	11	43	8	50	13
Diseases of Skin and Subcutaneous Tissue			99	21	50	10	41	8
Endocrine, Nutritional & Metabolic Disorders			121	13	192	34	261	25
Musculoskeletal System & Connective Tissue			16	4	92	16	32	9
Infective & Parasitic Diseases			19	5	50	17	47	14
Neoplasms			42	8	26	1	8	5
Causes of Perinatal Morbidity & Mortality			1	1	12	5	24	2
Diseases of Blood and Blood-forming organs			14	5	14	3	2	2
Congenital Anomalies							8	1

LEADING CAUSES OF INPATIENT CARE - Contract Care

SERVICE UNIT Harlem

	1989		1988		1987		1986	
	Days	Disch.	Days	Disch.	Days	Disch.	Days	Disch.
TOTAL			642	152	696	165	786	195
Pregnancy, Childbirth and the Puerperium			88	33	133	42	109	43
Accidents, Poisoning and Violence			88	26	97	27	131	36
Diseases of the Respiratory System			31	8	17	7	66	19
Diseases of Digestive System			84	16	139	30	132	23
ental Disorders			48	13	37	7	43	10
Symptoms and Ill-defined Conditions			8	5	11	5	23	7
Supplemental Conditions			12	4	7	2	10	3
Diseases of Circulatory System			93	13	73	13	41	10
seases of Genitourinary System			43	12	49	8	39	10
seases of Nervous System			22	3	6	2	46	8
Diseases of Skin and ubcutaneous Tissue			16	3	15	2	4	1
Endocrine, Nutritional & Metabolic Disorders			9	2			34	3
Musculoskeletal System & Connective Tissue			31	3	61	12	26	9
fective & Parasitic Diseases					20	2		
N oplasms			63	10	31	6	62	9
Causes of Perinatal orbidity & Mortality							9	2
Diseases of Blood and lood-forming organs							11	2
Congenital Anomalies			6	1				

Outpatient Visits

PROVIDERS OF SERVICE

Ft. Belknap Service Unit

DISCIPLINE	1989 Number	1989 (%)	1990 Number	1990 (%)	1991 Number	1991 (%)	1992 Number	1992 (%)
Total Outpatient Visits	26,012	100%						
Physician	13,120	50.4						
Clinic Nurse	1,531	5.9						
Licensed Practical Nurse	440	1.7						
Med/Psy. Social Worker	5	–						
Nutritionist	–	–						
Optometrist	434	1.7						
Pharmacist	7,057	27.1						
Physical Therapist	–	–						
Physician Assistant	2015	7.8						
Psychologist	–	–						
Public Health Nurse	100	0.4						
Pediatric Nurse Pract.	–	–						
Nurse Midwife	–	–						
Mental Health Technician	311	1.2						
Medical Student	253	0.9						
Nurse Practitioner	160	0.6						
Nurse Assistant	–	–						
Laboratory Technician	–	–						
Audiologist	280	1.1						
Pharmacy Practitioner	–	–						
All Other	306	1.2						
Primary Care Provider Visits	15,425	59.3						

STATEMENT OF MYRON ELLIS, MEMBER
LEECH LAKE RESERVATION BUSINESS COMMITTEE

ON

THE INDIAN HEALTH SERVICE'S RURAL HEALTH CARE DELIVERY SYSTEMS

BEFORE

SENATE SELECT COMMITTEE ON INDIAN AFFAIRS
U.S. SENATE

March 22, 1990

Mr. Chairman and Members of the Committee. I am Myron Ellis, Member, Leech Lake Reservation Business Committee (RBC), the governing body of the Leech Lake Band of Chippewa in Minnesota. We appreciate the opportunity to appear before the Committee today to present our views and recommendations on the Indian Health Service's Rural Health Care Delivery Systems. We commend Co-Chairman McCain and the Committee for identifying the need for Congressional oversight in this vital Indian health area, and we particularly commend the Co-Chairman for his commitment to sponsor remedial legislation to correct deficiencies identified through this hearing.

Before discussing the issue before the Committee, I believe it is important to comment briefly on the dynamics of rural health care delivery systems throughout the United States. Clearly, the character of health care in rural America is rapidly changing. Advances in medical practice increasingly require highly technical equipment, highly trained professional staff and highly complex health facilities, including hospitals and outpatient facilities. While these changes have led to improved diagnostic and treatment services for patients, the costs associated with such facilities, particularly hospitals, often exceed the financial health resources of many rural communities. As a result, scores of hospitals in rural communities across the country have been forced to close their doors to inpatients, and others will be forced to do likewise in the future. Moreover, since physicians tend to practice in those communities where hospital facilities are located, many of them will move elsewhere as rural hospitals are closed out.

As a result, rural residents are losing access to basic health and hospital services. They may not have public preventive health services readily available to them, and, unfortunately, they may not take the time and effort -- or be able -- to travel to an urban center for health care until their illnesses are far advanced and, therefore, more difficult and costly to treat.

The Leech Lake Reservation is highly integrated with approximately 12,000 non-Indians residing within the exterior boundaries. Together, we face the problems of isolated rural people everywhere in seeking quality curative and preventive health services. Given these circumstances, we believe there are opportunities to establish outpatient facilities to serve Indians and non-Indians alike.

An examination of rural health care delivery systems on Indian reservations and in Indian communities reflects problems and conditions similar to those found in non-Indian rural communities; however, the impacts in a reservation setting are often more severe due to adverse socio-economic conditions that contribute to excessive morbidity and mortality from diseases and illnesses that are preventable and that are essentially under control in non-Indian communities. In addition, Indian reservations and communities are generally more isolated than non-Indian communities, complicating access to health services. Admittedly, the Indian Health Service (IHS), a Federal agency charged with the responsibility for providing health and medical care to Indian people since July 1, 1955, has made major strides in the improvement of the health status of Indian people.

Notwithstanding an improved health status among Indians, study after study points to the fact that the need for IHS services far outstrips the agency's financial resources. Too often, due to fiscal constraints, basic health services are denied to those who present themselves at direct-operated IHS facilities or contract facilities. Due to broader fiscal concerns related to the budget deficit that confronts the Congress and the Administration, it is unlikely that there will be dramatic funding increases for IHS services in FY 1991. It is incumbent, therefore, upon the tribes and IHS to work cooperatively to insure that the limited Federal financial resources are utilized in the most efficient and effective manner.

We have been very encouraged by the interest displayed by Co-Chairman McCain and his Committee colleagues in their efforts to address the financial and other deficiencies underlying the IHS's rural health care delivery systems. We have been further encouraged by the Committee's recognition of the dilemma faced by several tribes, including the Leech Lake Band of Chippewa, whose IHS Hospitals have been identified for closure to inpatient care. Presumably, under such an arrangement, the IHS would replace such hospitals with health centers (for outpatient curative and preventive services) and all inpatient care would be referred to hospitals in non-Indian communities.

The hospital closure policy leaves no room for the tribes and IHS to exercise creativity to develop new delivery mechanisms, e.g., a facility that falls somewhere between a hospital and a health center with limited bed capacity to accommodate unique circumstances found in Indian communities. The IHS follows an "either or" policy in that a tribe can either fight to retain its hospital or acquiesce and accept closure and a health center operation. This is a misguided policy in that it inhibits tribal/IHS cooperation and creates instead an adversarial relationship that is counterproductive to sound health planning. I will elaborate further on this matter later in my statement.

At this point, we believe it is important to provide the Committee with certain data and information regarding health circumstances on the Leech Lake Indian Reservation so that our statement and legislative recommendations can be placed in proper context.

There are 1,050 square miles within the exterior boundaries of the Reservation; about five percent of the land is owned by the tribe and its members; and the balance is owned by private individuals, the Federal Government and others. The tribal membership consists of approximately 6,000 enrolled members; approximately 4,000 live on the Reservation, and the balance are broadly scattered elsewhere.

I have attached hereto a paper, "LEECH LAKE RESERVATION OVERVIEW OF HEALTH CARE NEEDS AND CONCERNS", that identifies the kinds of diseases and conditions that contribute to the excessively high morbidity and mortality among our people. You will note that our people suffer and die from diseases and conditions that are preventable; socially-based diseases, involving attitudinal problems; and chronic diseases, afflicting mostly the elderly. In virtually all instances, the morbidity and mortality rates among our people from these diseases and conditions greatly exceed those for the non-Indians.

The IHS facility on the Reservation that serves as a base for the services extended to our people is the Cass Lake Indian Hospital that was constructed in the 1930's. The facility houses an outpatient service for curative and preventive services, a laboratory and x-ray unit.

The hospital originally operated at a +30-bed capacity, however, over the years, the IHS has followed a practice of referring patents to nearby community hospitals on a contract basis. Presently, the Hospital operates at a 13-bed capacity. All major medical cases, obstetrics, etc. are referred to the community hospitals. Our Hospital can best be characterized as no more than a "holding" facility for the patients flowing to and from the community facilities.

As previously noted, the Cass Lake Indian Hospital has been identified among several others for closure by the General Accounting Office (GAO) and the Department of Health and Human Services (DHHS)/Inspector General. Under existing Federal Indian health policy, there is virtually no hope of IHS approving a replacement facility. Over the past several years, IHS officials have attempted to convince our governing body of the merits of closing the Hospital and converting it to a full-time health center where outpatient curative and preventive services would be provided to our people.

Ironically, the IHS officials argue against further use of the alleged obsolete and asbestos-laden facility as a Hospital, but, on the other hand, these officials expect the Band to use the very same facility as a health center. They have repeatedly stated that, if the Hospital is closed, its square footage would be factored into the IHS's Health Facilities Construction Priority System in considering a new health center at Cass Lake, and, given these circumstances, we would not qualify for a new facility. Obviously, our governing body is opposed to this arrangement. We now understand that the Ranking System has been modified to take into consideration the age and physical state of a closed-out hospital when it is proposed to be closed and replaced by a health center operation.

We contend that the IHS hospital closure policy is driven in large measure by the Office of Management and Budget (OMB) whose philosophy on Indian health services appears to be limited to provision of hospital inpatient services to the exclusion of preventive services and community action programs that are vital to the mobilization of community efforts to combat communicable diseases and certain psychological conditions (alcohol and substance abuse) that require community involvement to support control efforts. Unfortunately, the Department of Health and Human Services reinforces the OMB philosophy regarding the breadth and scope of Indian health services.

Given these circumstances, the several tribes, including the Leech Lake Band of Chippewa, whose hospitals have been identified for closure as a matter of public policy have precious little latitude to negotiate with the IHS on alternatives to closure. The RBC's experience in negotiations with IHS over several years on the future status of the Cass Lake Hospital is instructive in this regard.

The IHS officials, without producing valid evidence, argued that closure of the Cass Lake Hospital and its replacement by a health center would somehow enhance the quality of health services for our people. Faced with closure as the only option, the RBC, acting as the elected reservation political leaders, reacted defensively and opposed the closure of our facility. We believed that our hospital was being attacked by uncaring, higher echelons of government; that our people stand to lose ready access to inpatient care; that we would lose the "family" of sensitive hospital staff; and that the reservation community would lose a portion of its economic base through closure of the Hospital since many of our Band members work in this facility. We continue to oppose closure of our hospital even though all objective criteria rule against its long term retention.

Our Band and other tribal groups whose hospitals are scheduled for closure are victims of an IHS system that favors, perhaps unintentionally, the large, isolated tribes that have limited or no ready access to non-Indian facilities. I refer to the IHS's Health Facilities Construction Priority System, a complex process used by the IHS to establish priorities for the construction of hospitals, health centers, clinics and personnel quarters on specific Indian reservations. Congress has accepted this system and authorizes annual appropriations for construction of facilities identified by IHS pursuant to the Priority System.

Unfortunately, this administrative tool is too limited. It fails to address those tribes faced with hospital closures and precludes many small, scattered tribes from ever achieving a priority status because of their population base. Clearly, a new, constructive policy must be developed to overcome these deficiencies in the current system. We urge this Committee to assume the initiative in formulating such a policy since the OMB would more than likely block any well-intentioned policy in this regard originating in the IHS.

What is needed is a formal process for objectively identifying health needs and defining options compatible with the needs and desires of the Indian community -- all this to be done in a partnership between the Federal and tribal government. This is what Senator McCain proposes -- a process which can remove these decisions from the emotional/confrontational arena and place them in an objective and collaborative frame.

Exactly how to design and implement this "ideal" Indian health care system is, in our opinion, not known and certainly cannot be legislated or decreed from Washington based on our present knowledge. We believe that the expertise to work out these issues can be found in Indian communities, through work with their health staffs (both tribal and IHS). By establishing demonstration projects, the insights, skills, initiative, and vision of those at the Indian community level can be brought to the fore. The tribes, the IHS, the Administration and the Congress can see what is possible, what works, and then can establish a legislative framework which will permit all tribes, large and small, to focus on long-term solutions to their health facility needs rather than on "defending" their hospitals.

Our conclusion is the same as Sen. McCain's, that "any demonstration project that is ultimately put into place, will hold much promise because -- we are putting the keys for change into the hands of those who ought to have them -- the very people who are affected either positively or negatively by whatever health care service delivery system exists." By putting the keys for change -- the demonstration project -- in the hands of our tribal government, the Leech Lake Reservation Business Council, I believe that we can develop a health care system and the appropriate health facility that can meet our health needs more effectively. And I am also certain that I speak for many other tribal leaders throughout the country. Indian tribes have different circumstances, different access to health facilities, different opportunities for sharing services with other people, but every tribe has skilled and committed leaders who will take the initiative and the responsibility for working with the IHS and tribal health staffs to make the changes that are necessary and appropriate.

By having a number of demonstration projects, we can all benefit from the expertise and experience of many tribes. The tribal governments, the IHS and the Congress will then have the information to determine what changes should be made in the IHS delivery system, what flexibility would be appropriate, what new authorities are required, and what guidance the Congress must provide to the Administration in the implementation of the Indian health program. The direction of Congress to the Administration is especially important since experience during the past nine years has made it clear that the Administration, at the insistence of OMB, has no intention of providing any leadership for change in the present approach to Indian health facility construction -- no construction at all is the only position they have considered.

Mr. Chairman, we have given considerable thought to your contemplated legislation that would address the IHS's rural health care delivery systems, and, while we have not translated our thoughts on this matter into technical legislative language, we offer our suggestions in general narrative form as follows:

- Impose a statutory bar against the IHS's closure of the several hospitals identified by the GAO and the DHHS/Inspector General.
- Mandate the IHS to undertake baseline health studies on the reservations where the above hospitals are located to --Determine appropriate curative and preventative services to meet the needs of the people.

  Explore the feasibility of establishing joint-use out-patient facilities for Indians and non-Indians where these opportunities exist.

- Mandate the IHS to explore the feasibility of converting the hospitals identified for closure to "holding" or temporary recovery care facilities with sufficient bed capacities to accommodate anticipated caseloads.
- Authorize IHS to establish several demonstration projects to accommodate the joint-use and "holding" facilities concepts, establish such demonstration projects outside of the IHS's Health Facilities Construction Priority System.
- Provide a separate authorization for appropriations and mandate the IHS to submit annual reports to the Congress on the progress achieved in establishing the demonstration projects.
- Authorize tribes to participate in cost-sharing with the IHS for the construction of health facilities without jeopardizing the standing of less affluent tribes in the priority system.
- Mandate the IHS to work with the tribes and coordinate its rural health care delivery systems implementation with Federal, State, County, private and voluntary health care entities so that the experience gained may be utilized to improve the quality of health care, curative and preventive, for all of the Nation's rural citizens.

We are hopeful that our suggestions will assist you in drafting meaningful legislation to improve IHS's rural health care delivery systems.

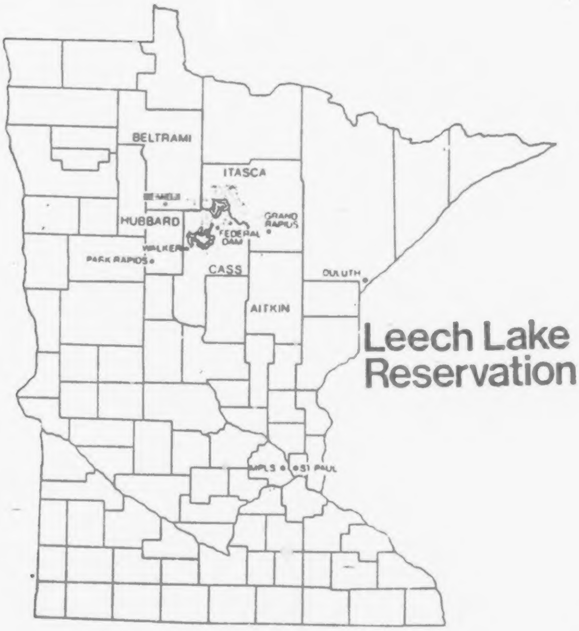
Mr. Chairman, this concludes my views and recommendations on the IHS's Rural Health Care Delivery Systems. I am prepared to respond to questions from the Committee.

LEECH LAKE RESERVATION
OVERVIEW OF HEALTH CARE
NEEDS AND CONCERNS

THE LEECH LAKE INDIAN RESERVATION

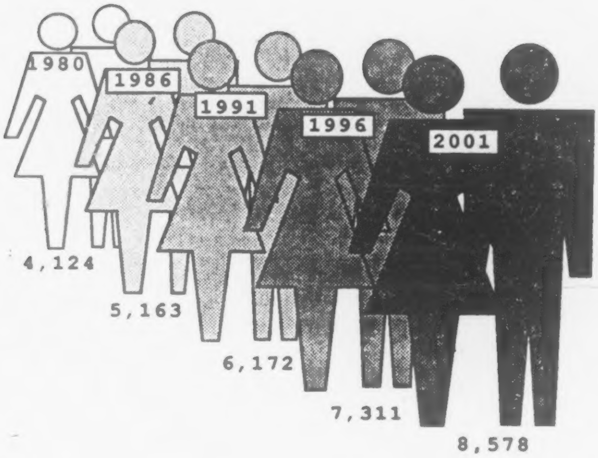
Located in north-central Minnesota, the Leech Lake Reservation is located about 200 miles north of the twin cities of Minneapolis and St. Paul and about 100 miles south of the Canadian border. The boundaries of the Reservation enclose about 1,050 square miles., although only about five percent of that is owned by the tribe or by individual Indians.

There are about 6,039 enrolled members of the Leech Lake Band of Chippewa Indians. Approximately 4,000 Indians live on the Reservation and another 1,000 live adjacent to the Reservation.


BELTRAMI
ITASCA
BEMIDJI
HUBBARD
GRAND RAPIDS
FEDERAL DAM
WALKER
PARK RAPIDS
CASS
DULUTH
AITKIN
MPLS
ST PAUL

Leech Lake Reservation

POPULATION PROJECTIONS
GREATER LEECH LAKE SERVICE UNIT



The Indian population of the Leech Lake Service Unit is expected to double from 1980 to 2001.

In just ten years, from 1986 to 1996, the number of Indian people in the Leech Lake area will increase by over 2,000.

HEALTH PROBLEMS

In 1981-83, the birthrate for Indians in Minnesota was 36.9 births per 1000 population. This compares to a statewide birthrate of 16.1, and a national birthrate of 15.7. The Indian rate is more than twice that of the state and the nation. The birthrate for the Leech Lake service unit was 46.3, nearly three times the state average.

Infant mortality, an important indicator of the health of a people, has been declining for all races, but the Indian rate is still considerable higher than the state as a whole. For 1981-83, the infant mortality rate (deaths per 1,000 births) was 9.4 for all races in Minnesota, 10.8 for Indians statewide, and 13.7 for the Leech Lake service unit. As the following table shows, neonatal and postneonatal infant deaths are significantly higher among Indians and higher yet for the Indians of Leech Lake.

	Leech Lake	Minn. Indians	Minn. All Races
Neonatal death rate	7.7	6.0	5.9
Postneonatal death rate	6.0	4.9	3.5

(rates are per 1,000 live births)

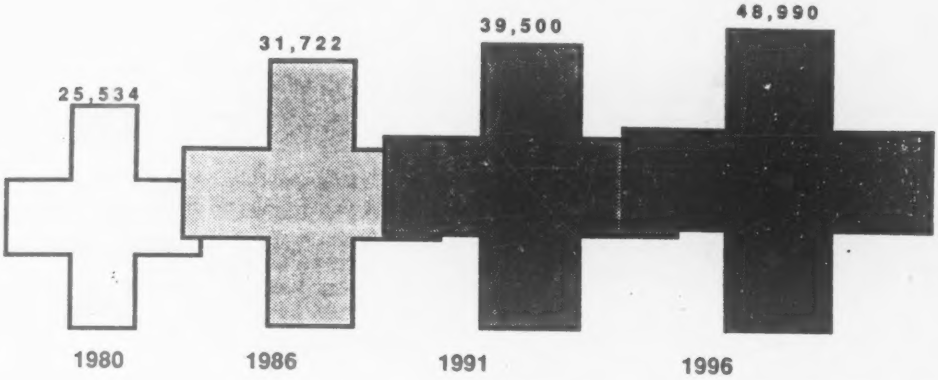
Cause-specific Deaths and Crude Death Rates per 100,000
1981-83

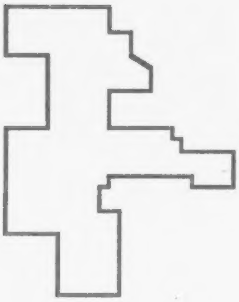
	Leech Lake	Indians	All Races
Liver Disease/Cirrhosis	28.2	14.3	8.3
Accidents/Adverse Effects	175.5	136.8	36.0
Motor Vehicle Accidents	104.8	80.8	15.5
Influenza/Pneumonia	56.2	32.3	29.2
Homicide	21.7	10.9	2.5
Diseases of the Heart	148.7	202.7	294.8
Malignant Neoplasms	35.5	88.4	178.1
Cerebrovascular Diseases	21.0	32.4	72.1
Diabetes Mellitus	7.0	28.5	13.4
Suicide	14.3	16.1	10.9

Source: Bemidji Area Tribal Specific Health Plan & Summaries
Area Profile FY 1985, Bemidji Area IHS.

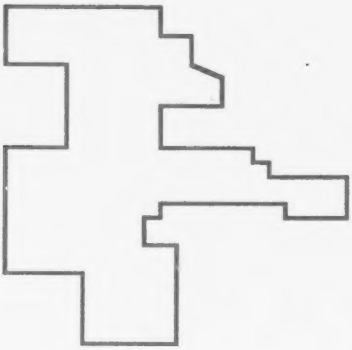
The Leech Lake Reservation has much higher rates of mortality for liver disease, accidents, homicide and influenza/pneumonia. These statistics, combined with the data on perinatal deaths and prenatal care indicate that the status of health on the reservation remains well below state and national averages.

NUMBER OF OUTPATIENTS PROJECTED BY 1996





Present space consists of 12,887 sq.ft.



Twice the existing space will be needed by 1996.

The Cass Lake Indian Hospital was built in the 1930's and has had additions and separate buildings added on over the years to accomodate the increasing health needs of the service area.

Additional expansion opportunities are limited.

The presence of asbestos in the building makes renovation very expensive.

The current facility is inefficient and overcrowded.

Only 13 patients can be accomodated in the inpatient care ward.

MAJOR HEALTH CARE CONCERNS

- POSSIBLE ELIMINATION OF INPATIENT CARE AT THE CASS LAKE INDIAN HOSPITAL.
- CROWDED AND INEFFICIENT OUTPATIENT CLINIC AND HOSPITAL.
- INADEQUATE FUNDING FOR CONTRACT HEALTH CARE RESULTING IN LOSS OF CARE FOR TRIBAL MEMBERS.
- SUBSTANDARD SATELLITE CLINIC FACILITIES.

TRIBAL PRIORITIES

- TO MAINTAIN THE CURRENT LEVEL OF INPATIENT CARE, AT LEAST UNTIL THE ISSUE CAN BE STUDIED FURTHER.
- TO MOVE TOWARD CONSTRUCTION OF A NEW HEALTH FACILITY.
- TO UPGRADE THE SATELLITE CLINICS WHICH SERVE THE REMOTE AREAS OF THE RESERVATION.
- TO INCREASE THE AMOUNT OF CONTRACT CARE FUNDING.
- TO DEVELOP MORE EMPHASIS ON HEALTH PROMOTION AND DISEASE PREVENTION.

TESTIMONY OF TRIBAL CHAIRMAN RUSSELL HAWKINS
OF THE
SISSETON-WAHPETON SIOUX TRIBE
BEFORE THE
SENATE SELECT COMMITTEE ON INDIAN AFFAIRS
REGARDING EFFORTS FOR A
REPLACEMENT HEALTH FACILITY
AND THE
INDIAN HEALTH SERVICE FACILITIES CONSTRUCTION PRIORITY SYSTEM

March 22, 1990

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for this opportunity to describe the Sisseton-Wahpeton Sioux Tribe's efforts over two decades to get a replacement health facility for the Indian people of the Lake Traverse Reservation in north east South Dakota. The process has been thwarting us for two decades. Despite unquestionable need and persistent effort, Sisseton is still not on a priority list for a replacement health facility.

DESCRIPTION OF SISSETON'S EFFORTS TO GET A REPLACEMENT HEALTH FACILITY:

The existing facility was constructed in 1936 and began providing patient care in 1937.

During the 1960's there were remarkable advances in health technology. By the 1970's, it became apparent that the facility was out-of-date. The Indian Health Service conducted several studies, which confirmed that the facility needed to be replaced.

Pursuant to Tribal Council Resolution No. 77-13, enacted January 6, 1977, the Sisseton-Wahpeton Sioux Tribe used the authority of P.L. 93-638 and conducted a Comprehensive Master Planning Study of health and medical facilities resources and needs. Based on the findings of that study, Tribal Council Resolution Numbers 77-33 and 77-34 were passed on April 5, 1977, stating that:

> The existing Sisseton Indian Health Service Hospital was functionally and physically inadequate;
>
> It was not feasible or cost-effective to repair or replace the facility at its existing site;
>
> The Tribal Chairman was authorized to obtain funds for design and construction of a new Hospital; and,
>
> The Director of the Indian Health Service was asked to advocate for design and construction funds for the new Sisseton Indian Health Service Hospital, as specified by the Tribe's Master Planning Study.

Congress responded by appropriating $400,000.00 for an Architectural and Engineering Design study.

However, in 1978, the Office of Management and Budget froze the $400,000 appropriated for A&E. This was because the Sisseton Indian Health Service Hospital's inpatient utilization did not meet the new bed/patient methodology criteria imposed at that time for justifying construction needs. The Tribe contended that the standard, requiring an 80% optimum bed occupancy rate, was not applicable in rural communities (and most certainly not on an Indian Reservation). The new standard failed to take into account the many reasons why an 80% occupancy rate had not been feasible at Sisseton.

On June 5th, 1979, Tribal Council Resolution No. 79-73 was passed, requesting the Office of Management and Budget to release the monies appropriated by Congress so that they could be used for the intended purpose. Resolution No. 79-73 goes on to state, "That in the event that Congress determines not to release the A&E monies, the Sisseton-Wahpeton Sioux Tribe states its intent to submit an alternative proposal, to use the appropriated monies in development of a Program Information Document for an Outpatient Services/Extended Care facility."

On September 4, 1979, Tribal Council Resolution No. 79-94 was passed, again requesting that the Office of Management and Budget release the $400,000.00 and submitting the following alternative approaches to address the intent Congress had in appropriating funds for the Sisseton-Wahpeton Sioux Tribe:

1. To complete the A&E Design for construction of a comprehensive inpatient/outpatient services facility, according to the original plan; or,
2. To compile a Program Information Document and then initiate Architectural and Engineering Design development for construction of an Outpatient Services/Extended Care Facility, with inpatient services provided through Contract Health Service (CHS) funds; or,
3. To study the renovation and repair work which would be required to modernize the present facility and then actually begin massive-scale renovation."

One year later, on September 4, 1980, Tribal Council Resolution No. 80-70 was passed, supporting the Program Information Document for alternative #2, a Comprehensive Health Facility.

Following up on an action at a General Council Meeting held May 22, 1981, Resolution No. 81-105 was adopted August 4, 1981, requesting the Indian Health Service to proceed with the steps necessary to document need and provide Tribal members access to adequate, modern health facilities. It charged that alternative #1, a comprehensive inpatient/outpatient services facility, be pursued, according to the original plan.

That did not happen. Therefore, on March 8, 1984, the Tribal Council adopted Resolution No. 84-27, which requested that the Indian Health Service prepare a Program Information Document for a replacement outpatient clinic facility and then followup to secure the necessary resources.

In order to maintain Medicare/Medicaid certification, the Sisseton Indian Health Service underwent Phase I. renovation in 1984 at a cost of $626,900.00 which Medicare/Medicaid collections paid for. Major structural problems with Radiology, Laboratory, and Emergency Room components were corrected.

This renovation did not address the urgent need for a replacement clinic. The dilapidated, 1,456 gross square foot trailer, which was being used as a clinic, had far-exceeded its life-expectancy. The double-wide trailer did not meet space requirements for 20,000 outpatients per year. There was an appalling lack of privacy in that facility. There were only four exam rooms and virtually no storage space. It also failed to provide security for drugs. And most of all, it did not meet fire and life-safety standards and code-requirements. The State Fire Marshall condemned it for use as a clinic. An IHS architect also studied the facility and agreed that it must be replaced.

However, still nothing was done. The Tribe was advised that only the top five ranking projects in the Area were formally planned for by the Indian Health Service facilities construction system (through preparation of a Program Justification Document and submission of formal budget requests to Congress). The need at Sisseton ranked sixth in the Aberdeen Area at that time, in a list that was not being addressed very speedily.

On February 5, 1986, the Tribal Council adopted Resolution No. 86-19, which authorized a feasibility study on use of Tribal funds to construct a replacement outpatient clinic at Sisseton. The Tribal Planning Office actually prepared site and floor plans for a replacement clinic. The Resolution also stated that the Tribe should obtain Congressional authorization to increase the gross square footage of the facilities at Sisseton, in order for the Indian Health Service to lease the facilities, once the Tribe had constructed them.

However, the need to replace the outpatient clinic was too desperate to allow time for this course of action. In 1986, the Tribe obtained authorization from Congress to use the President's Modernization and Repair appropriations and to waiver the moratorium restricting the Indian Health Service from adding any square footage, in order to put another temporary structure at Sisseton. In 1987 a modular unit was moved in and connected to the existing facility. This is being used today as a clinic. There were no additional staff or funds provided with this temporary structure.

Also, to date, the existing Indian Health Service facility has not been upgraded to resolve problems with the plumbing, electrical, heating, and mechanical works.

In October, 1987, the Tribe was notified that it had finally been placed on a list of potential projects to receive consideration for the priority list. Work began, once again, on the Program Justification Document. Tribal Council Resolution No. 88-62 was passed on January 22, 1988, formally requesting that the Indian Health Service prepare and submit a Program Justification Document for a Comprehensive Health Center to be located at Agency Village. The Health Center would include the required number of staff, new equipment, and sufficient operating funds for the following components:

1. Ambulatory Patient Care;
2. Emergency Room (Level II);
3. Community Health Services;
4. Administrative Services;
5. Staff Housing; and,
6. Space for Tribal Health Programs.

To assist in the preparation of the Program Justification Document, Tribal

Council Resolution No. 88-84 was passed April 6, 1988, designating four potential construction sites for the Comprehensive Health Center.

Various drafts of the Program Justification Document were reviewed by the Tribe. An acceptable document evolved. Finally, the product was submitted to Indian Health Service Headquarters in August, 1988.

Days later, in the first week of September, 1989, the Indian Health Service received instruction from Congress to revise its Facilities Construction priority methodology. Headquarters suspended the work it was doing. Sisseton's Program Justification Document was not reviewed.

On February 24, 1989, I visited IHS Headquarters for the purpose of requesting that the Sisseton project be "grandfathered" in under the old methodology (which had been in place when Sisseton's Program Justification Document was submitted in August, 1988). This request was reasonable and sensible in view of the extensive history, which I have just related, and nearly a year of effort in preparing the Program Justification Document. However, instead, I was advised at Headquarters that the new formula had already been applied. Sisseton did not make it into the priority system, using the new methodology. No Aberdeen Area construction projects made it. Forty percent (40%) of those on the list were from the Oklahoma City Area. Several sites on the list had already had new construction. Most were not located in rural or isolated areas. It was apparent that the formula favored the large, high workload facilities.

At the request of the Director of the Aberdeen Area Indian Health Service, Dr. Terrence Sloan, and myself, it was agreed to suspend action on the new priority list until the methodology could re-evaluated.

Information about what recommendations had resulted from this reevaluation was circulated during April, 1989. Although the proposed adjustments in the methodology could result in higher scores for remote (isolated) locations and for older facilities, the Sisseton-Wahpeton Sioux Tribe was concerned that the recommended changes in the methodology did not address the medical risk or relative health status of the respective populations (as measured by mortality rates, Years of Potential Life Lost, or other valid indicators).

The Sisseton-Wahpeton Sioux Tribe, therefore, sent a delegation to the "Denver 89 - Consultation in Process" Meeting held in May, 1989. There, I expressed my concern about the methodology and its failure to address Sisseton's need for a replacement health facility.

The following week, Tribal Council Resolution No. 89-025 was adopted (May 10, 1989), requesting a Congressional inquiry into what actions the Indian Health Service would take to assure a more equitable distribution of resources, so that reasonable trust responsibility would be met at locations like the Lake Traverse Reservation, where:

> There has been no new construction since 1936;
>
> There are chronic budget shortfalls that further limit access to health care; and,

> The morbidity and mortality rates continue to lag disgracefully behind those of "IHS All Areas" and "U.S. all races."

On September 15, 1989, I again visited IHS Headquarters to propose that the Sisseton replacement facility be "grandfathered" onto the priority list under the old methodology. I was advised that there was no priority list at that time and that the Office of the Inspector General was studying the methodology. I learned that there were to be Congressional hearings on the methodology.

That is why I am here today -- to respond to the methodology and the IHS Facilities Construction process, which has not addressed our need, despite persistent efforts, spanning two decades.

HAS THE SISSETON REPLACEMENT HEALTH FACILITY BEEN ON THE IHS FACILITIES CONSTRUCTION PRIORITY LIST IN THE PAST?

It was clearly the intent of Congress and the Indian Health Service to replace the Sisseton Hospital in 1978, when monies were appropriated for A&E Design. A Program Information Document was prepared at that time. That predated the IHS Facilities Construction Priority System, as we know it today.

In 1980, Sisseton was on the priority list. A second Program Justification Document was prepared. There were five projects in the

Aberdeen Area ahead of us at that time.

Then in 1988, we were on a priority list again. A Program Justification Document was prepared for the third time. However, then the formula changed, and we were back to "Start".

Not only was Sisseton affected, but also the Manderson Clinic for the Oglala Sioux Tribe.

KINDS OF ASSISTANCE THE INDIAN HEALTH SERVICE HAS PROVIDED TO DATE:

I have worked very closely with the Aberdeen Area. The Area Director and his staff have been supportive. However, IHS Headquarters has not been responsive. They have not honored my request to have Sisseton "grandfathered" in under the old priority system. I do not believe that they have sufficiently changed the Facilities Construction formula so that Sisseton can make it into their priority system when the new formula is applied.

WHAT IS WRONG WITH THE FORMULA. WHY SISSETON CAN NOT MAKE IT ON THE PRIORITY LIST UNDER THE NEW METHODOLOGY: (Copy of formula attached to this narrative)

There are several reasons why I think the methodology does not provide for a reasonable, comparative analysis of small, rural facilities like Sisseton. The first has to do with **SPACE**.

The existing formula starts out REQUIRE SPACE minus EXISTING SPACE. A problem here is that the IHS methodology requires that the square footage of all permanent structures be considered. The current formula does not take into account that our proposal is for an ambulatory health center. Rather, it requires us to count the old inpatient facility, the garage that is being used for Property and Supply, old quarters, etc. Another example of this is at Rapid City, where the third floor (condemned for patient care purposes), Black Hills Training Center, and ancillary building space must all be included. I believe that only the space currently used for outpatient care should be used in the formula.

Related to **SPACE**, is the problem of **SIZE**. The current formula favors large, high workload facilities. The smaller facilities can not compete with the large facilities on workload. Moreover, the formula does not consider that in rural settings the population is less dense. Access to health care is critical. Plus, the burden of illness is remarkably higher in the isolated Reservation populations of the Dakotas. I believe that there should be two formulas and/or two formula applications: one for the large, high workload facilities, and another for the smaller facilities. Once on the priority list, the small facilities should receive equal consideration with the larger facilities for funding.

AGE OF FACILITY is the third problem. The current formula provides an Age Adjustment Factor, based on the age of the facility. For example, in a 45 year old facility, the percent of existing space deemed "usable" would be 60% This factor is multiplied to the EXISTING SPACE factor, thereby adjusting it lower. I do not believe that the adjustment schedule established for this factor is sufficient. I think it is unfair for facilities constructed fifty or more years ago to have to compete with those only a couple of decades old. Replacement of archaic IHS facilities, those constructed prior to 1940, should receive first consideration.

ACCESS is a fourth problem. The current formula includes an adjustment factor based on the number of miles to the nearest Emergency Room (Level I, II, or III). I believe that this factor is not a true indicator of isolation. I do not, first of all, believe that access to a Level III Emergency Room should be the standard. (Level III means to have an emergency medical service-qualified physician on call and available within 30 minutes.) The Sisseton Indian Health Service Emergency Room itself has the capability to stabilize and refer, as do other small, rural hospitals. A better test of isolation is access to the tertiary facilities that have the specialists and technology to treat the patients As an example, a cardiac emergency, whether at Sisseton Indian Health Service or at another rural, community hospital in South Dakota, is going to have to be referred to Fargo or Sioux Falls. Those are the distances which need to be considered.

Further, if the existing Isolation Adjustment Factor is to be used, then it should be adjusted higher for distances over twenty-five (25) miles. In Sisseton's case, it is sixty (60) miles to a Level I or II Emergency Room. Under the existing formula, the adjustment factor would be only 1.15, which is not sufficient, particularly in view of winter driving conditions in northeast South Dakota. Overall, I question whether miles distance to an Emergency Room is a valid test for ACCESS or ISOLATION.

Fifth, the formula does not take **STAFFING** into consideration. New construction is the only time an IHS facility's budget, staffing, and equipment needs are re-evaluated and addressed. Adjustments are then built into the new construction funding package. According to another IHS formula, the Resource Requirement Methodology, which is used in preparing the Program Justification Document and Program of Requirements, the Sisseton Indian Health Service is staffed at 39% of "optimum staffing levels". Because of budget and staff shortages and resulting "burnout", there is a high turnover in physicians and nurses at Sisseton.

We can not recruit and retain physicians, for example. In the last year, Sisseton has lost two Clinical Directors (head physicians), Dr. Hoover and Dr. Reser, because the workload is so overwhelming and the resources are inadequate. Dr. Reser, who left Sisseton in September, stated that she had to leave for her own personal survival. Beyond eighty hours of regular duty and thirty hours of compensated overtime per pay period, Dr. Reser found that she was donating 10-20 more hours on her own. The Sisseton IHS Emergency Room averages 350 visits per month. About 30% of these are true emergencies. The remainder are urgent care situations. Many of these patients are utilizing the Emergency Room because the clinics are too full during the day.

Quality of care is directly affected by lack of continuity in providers and by providers who are too busy to take the time needed to work with the patient. At present, we have only one "permanent" physician on board at the Sisseton Indian Health Service. We cannot recruit replacements for the doctors who left in July and September. IHS is arranging for a series of temporary physicians to come in. They stay for a couple of weeks or a month. This is not a unique situation. We have had many, many of these temporaries over the years. During a recent one-year span, we actually had thirty-three different physicians at our facility! They are unfamiliar with the patients' medical histories. There is no opportunity for a trust relationship to develop. The temporary physicians often change treatment regimens. The next doctor who comes changes them again. The patient sees a seemingly endless number of physicians, all asking them the same questions. Patients frequently wonder whether their treatment is appropriate or adequate. Many feel this is the reason why their health is not restored.

Health care delivery is labor intense. Therefore, there will continue to be wide disparity in health delivery systems throughout the Indian Health Service, until the priority system formula focuses program growth toward critically understaffed facilities, particularly those which have consistently high morbidity and mortality rates.

A sixth problem with the formula is that it does not consider **BURDEN OF ILLNESS**. Consider the following comparison of mortality rates for the Sisseton-Wahpeton Sioux Tribal population per 100,000 to U.S. All Races for years 1984-86, the years for which the most recent information is available:

Leading Causes of Death	DEATHS PER 100,000 POPULATION (1984-86) U.S. All Races	SWST	RATIO SWST TO U.S. ALL RACES
Diseases of the Heart	175.0	292.5	1.67
Accidents	35.2	112.2	3.19
Malignant Neoplasms	133.2	132.9	0.99
Suicide	175.0	292.5	1.67
Chronic Liver Disease/ Cirrhosis	9.2	59.1	6.42
Cerebrovascular Disease	31.0	56.1	1.80
Chronic Obstructive Pulmonary Disease	18.8	39.0	2.07
Diabetes Mellitus	9.6	27.0	2.81
Pneumonia/Influenza	13.5	23.9	1.77

Infant mortality was not one of the ten leading causes of death for the Sisseton-Wahpeton population for the years 1984-86. However, in the previous three-year span (1983-85), the rate for "Conditions Originating in the Peri-natal Period" was 16.9, compared to 10.8 for "U.S. All Races". The Sisseton-Wahpeton Sioux Tribe's rate was 1.68 times higher than 'U.S. All Races'. In 1986, the latest year for which data has been compiled, the infant mortality rate was 19.1 deaths per 1,000 live births for the Sisseton-Wahpeton Sioux Tribal population. The IHS nationwide rate for 1984-86 was 11.1. For the Aberdeen Area Indian Health Service, overall, it was 19.6 deaths per live births.

I believe that infant mortality and the other high indicators of morbidity and mortality on the Lake Traverse Reservation are directly associated with the antiquity of the existing facility, the resulting staff and budget deficiencies, staff "burnout", staff turnover, and difficulty the patient encounters in accessing the clinic.

Also, the Sisseton-Wahpeton Sioux Tribe's **BURDEN OF ILLNESS** is not considered when projecting the number of Primary Care Provider Visits. Primary Care Provider Visits is the workload element used for calculating what the **REQUIRED SPACE** should be in the formula. The formula assumes that patients are accessing services sufficiently, since Sisseton's outpatient utilization rate in 1988 was 4.7 Primary Care Provider Visits per user per year does not account for the **BURDEN OF ILLNESS** in our population. Our Primary Care Provider Visits per user would, in fact, be higher than 4.7 visits per year if the patients could get in to be seen.

Primary Care Provider Visits would also be higher if there was more continuity in physicians. For example, about half of our prenatal patients are not coming in for prenatal care until the second or third trimester. I believe more would seek early prenatal services if they could expect to see the same physician and if there was less congestion in the facility. Infant mortality could be reduced through better quality prenatal care.

My final problem with the formula is that it fails to consider the relative **SOCIO-ECONOMIC CONDITIONS** of the populations served. The unemployment rate on the Lake Traverse Reservation is 75%, according to the current Bureau of Indian Affairs Labor Force Report. It has been between 70% and 82% since 1980. This means that there is a lot of poverty. There are several implications of poverty on health care:

*One is that the majority of Indian persons on the Lake Traverse Reservation do utilize the Sisseton Indian Health Service to the extent that they can access it. In other locations where there is more employment, Indian employees may participate in group health insurance plans. Therefore, they probably utilize IHS less for their health care. They are financially more able and, therefore, less dependent on the Indian Health Service.

*Secondly, as much as half of our population does not have dependable transportation to get themselves in for health care.

*Thirdly, many families do not have funds to maintain safe and sanitary living environments. Water and sewer, for example, are still unmet needs in many Indian homes.

The Indian Health Service Facilities Construction methodology fails to consider all these factors. Therefore, I do not believe that it provides fair, comparative analysis for the Sisseton-Wahpeton Sioux Tribe.

HAVE YOU DISCUSSED THESE CONCERNS WITH THE INDIAN HEALTH SERVICE?

Yes, I addressed many of them at the 'Denver 89" consultation meeting, held last May. I have a third visit to IHS Headquarters scheduled November 14th on this same issue.

WHAT CAN BE DONE AT THIS JUNCTURE:

I request that the Sisseton Indian Health Service facility be "grandfathered" onto the priority list. There clearly has been intent for Sisseton to have a new facility, both from Congress and from the Indian Health Service, over the past two decades. A great deal of time, energy, and money has been invested. We came very close a year ago to getting into the system. Then the formula changed. I have serious doubts about the fairness of the current formula, as it applies to small, rural facilities like Sisseton. For the reasons I listed, Sisseton will probably not make it into the priority system if the new formula is used.

The Sisseton-Wahpeton Sioux Tribe requests that the Senate Select Committee support our request to be "grandfathered" onto the Indian Health Service facilities construction priority list.

Mr. Chairman and members of the Committee, I appreciate this opportunity to testify.

Respectfully submitted by,

Russell Hawk

Russell Hawkins
Tribal Chairman
SISSETON-WAHPETON SIOUX TRIBE

CHRONOLOGY - SISSETON SERVICE UNIT

1937 - SISSETON FACILITY OPENED WITH A STAFF OF 17:

2 Physicians 1 Indian Assistant 1 Assistant Cook
2 Ward Attendants 5 Nurses 1 Orderly 1 Laborer
1 Engineer 2 Fireman

POPULATION - 2,835

OUTPATIENT - 585 patients, 45 patients per month, 35 beds.

FUNCTIONAL FACILITY PROBLEMS: Ward arrangement, lack of health education, prevention, due to lack of time, size of service area. Long distances to the population (Waubay and Veblen areas).

1977

Sisseton-Wahpeton Sioux Tribe, Planning Office received 638 Contract with Indian Health Service for a Comprehensive Master Planning Study and other Facility Analyses. Evaluation found present Indian Health Service Unit at Sisseton functionally and physically inadequate to provide the architectural framework necessary to meet long range needs of the Indian Health Service and the Sisseton-Wahpeton Sioux Tribe, and further, that available options to remedy this condition at the present site are not functionally feasible or cost justified.

Congress appropriated $400,00.00 for archiecture/engineer design.

1978

OMB froze $400,00.00 allocation for design for a replacement hospital/clinic facility.

A new methodology criteria was imposed at that time which the Tribe felt was not applicable in rural communities, especially not on Indian Reservations.

1980

Sisseton Indian Health Service prepared a program information document which was ranked within the top 10 priority facilities for replacement, per application of the Government's Facilities Construction Priority System Methodology.

1981

Government's General Accounting Office targeted Sisseton Indian Health Service Hospital to be closed due to lack of cost effectiveness.

Sisseton Indian Health Service replacement facilities construction project was removed from the Indian Health Service Facilities Construction Priority list.

1988

Indian Health Service Headquarters Office of Program Planning, Education and Legislation asked "Priority Committee" for another list of potential projects to be funded in FY/1991.

Sisseton identified as one of the eleven (11) additional facilities to be considered. Considered as one above and beyond the eighteen (18) projects already on the priority list.

Sisseton Indian Health Service prepared a Program of Requirement Program Justification Document for a Comprehensive Health Center including:

1. *Ambulatory Patient Care*
2. *Emergency Room (Level II)*
3. *Community Health Services*
4. *Administrative Services*
5. *Staff Housing*
6. *Space for Tribal Health Programs*

as well as, required number of staff, new equipment, and sufficient operating funds.

The Methodology for the Indian Health Service Facilities Construction Priority List was changed. The Sisseton Indian Health Service Program Justification Document was not processed.

SISSETON-WAHPETON SIOUX TRIBE
OF THE
LAKE TRAVERSE RESERVATION
SISSETON, S.DAK. 57262

TRIBAL COUNCIL RESOLUTION NO. SWST-89-025

WHEREAS, The Sisseton-Wahpeton Sioux Tribe of the Lake Traverse Reservation is organized under a Constitution and By-Laws adopted by members of the Tribe on August 1-2, 1966, and approved by the Commissioner of Indian Affairs on August 25, 1966; and,

WHEREAS, Article VII., Section 1 of the Constitution authorizes the Tribal Council to: (a) represent the Tribe in all negotiations with Federal, State, and local governments; (g) to take any actions by ordinance, resolution, or otherwise which are reasonably necessary, through committees, boards, agents, or otherwise, to carry into effect the foregoing purposes; and, (h) to promote public health, education, charity, and other services as may contribute to the social advancement of the members of the Sisseton-Wahpeton Sioux Tribe; and,

WHEREAS, - The Council has established the Human Services Board as an advisory and policy-recommending board in matters pertaining to the health and welfare of Tribal members; and,

WHEREAS, When the Indian Health Service hospitals and clinics were constructed, they were staffed and budgeted according to the need demonstrated at that time (which was 1936 for the Sisseton Indian Health Service); and,

WHEREAS, Indian Health Service facilities have continued to operate with the same basic historical budgets (plus modest inflationary increases) and staff position ceilings since the time of their construction; and,

WHEREAS, New construction is the only time the facility's budget, staffing, and equipment needs are re-evaluated, and adjustments are then built into the new construction funding package; and, WHEREAS, In 1978, Congress mandated the Indian Health Service to develop and apply a Facilities Construction Priority System as a means to identify the locations with the most urgent needs for replacement facilities; and,

WHEREAS, The present Facilities Construction Priority System Methodology includes the following variables: Workload (i.e., Average Daily Patient Load, Outpatient Visits), Cost to Repair Existing Facility, Cost to Replace Existing Facility, Cost to Correct Identified Deficiencies, Total Space Available Within Existing Facility, Isolation, and Availability to Alternate Resources; and,

WHEREAS, The methodology fails to consider the age of the facility and associated eras of medical technology, construction factors, or accessibility measures (i.e., number of providers per 1,000 population); and,

WHEREAS, Nor does the methodology take into account all the extenuating circumstances and reasons why the workload at the Sisseton Indian Health Serivce has been low, including the following:

1. Due to hiring freezes through the years, there have been times when only one physician has been on board at a three-physician station, and hiring for other key positions has been frozen, as well;

2. Because the budget is based on the 1936 need and is inadequate, key positions (such as nurses) have sometimes been lapsed, resulting in referral of inpatients who could otherwise have been cared for at the Sisseton Indian Health Service;

3. There are not a sufficient number of providers and exam rooms, so the number of patients who can physically access the services is limited and waiting times are lengthy; and,

4. Because of budget and staff shortages and resulting "burnout", there is a high turnover in physicians and other personnel, which further affects the workload; and,

WHEREAS, A vicious cycle has resulted that, because of lack of facilities (and staff), the Sisseton Indian Health Service workload is not as high as it could be; yet, without the workload, Sisseton can not get the facilities, staff, and operating budget it needs; and, WHEREAS, The Aberdeen Area Indian Health Service has had the least amount of new construction of all the Areas in the Indian Health Service and, consequently, is the most chronically underfunded Area for its population base; and,

WHEREAS, The Aberdeen Area Indian population has the very worst mortality and morbidity rates in the entire Indian Health Service (an infant mortality rate almost twice as high as "All IHS Areas", as an example); and,

WHEREAS, The Indian Health Service Facilities Construction Priority System Methodology was recently revised and applied generating the following locations as having the most urgent need for new construction:

HOSPITALS:

1. Claremore, Oklahoma City Area
2. Gallup, Navajo Area
3. Kayenta, Navajo Area
4. Riverside, California Area
5. San Carlos, Phoenix Area

HEALTH CENTERS:

1. Chief Andrew Issac, Alaska Area
2. Ganado, Navajo Area
3. Kayenta, Navajo Area
4. Muskogee, Oklahoma City Area
5. Okemah, Oklahoma Area
6. Riverside, California Area
7. Salina, Oklahoma City Area
8. Tulsa, Oklahoma City Area

(Note that there are no Aberdeen Area Construction projects included in the above list); and,

WHEREAS, At the request of the Sisseton-Wahpeton Sioux Tribe and Director of the Aberdeen Area Indian Health Service, (see Attachment A) the new IHS Facilities Construction Methodology is currently being re-evaluated by the Council of Associate Area Directors and IHS Headquarters staff; and,

WHEREAS, In a memorandum dated March 30, 1989, addressed to All Area Directors, entitled "Recommendations for Changing the IHS Facilities Construction Priority System", (Attachment B) the Indian Health Service Headquarters Associate Director, Office of Environmental Health and Engineering, Bill F. Pearson, P.E., L.S., proposed the following changes in behalf of the IHS Facilities Construction Priority System Committee:

1. During Phase II., the Methodology will adjust the Priority Score for proposed inpatient facilities by using a multiplier, "Weighting Factor for Availability of Alternate Resources and Isolation where Inpatient Facilities are Proposed", which will decrease the Priority Score for facilities where alternatives are available and will increase the Priority Score where the distance to alternatives is excessive (where the facility is isolated);

2. During Phase II., the Methodology will adjust the Priority System for proposed outpatient facilities by using a multiplier, "Weighting Factor for Isolation of Populations where Outpatient Facilities are Proposed", which will increase the Priority Score where distance to alternatives is excessive;

3. During Phase II., the Methodology will increase the score for facilities where the age of the existing facility exceeds ten years by using "Points to be added to the Priority Score for Age of Facility" to determine how much the score will be increased;

   If all else is equal, these adjustments in the scoring will result in higher scores for remote (isolated) locations and for older facilities; but,

WHEREAS, These recommendations still do not address the risk or relative health status of the respective populations (as measured by mortality rates or other valid indicators); and,

WHEREAS, There are serious doubts and much lack of confidence in the IHS Facilities Construction Priority System Methodology and the laborious process which must be used to upgrade an Indian Health Service System; and,

WHEREAS, Skepticism is reinforced by the Indian Health Service's recent proposal (see Attachment C) to make up the entire $11.7 million recission package requested by President Bush from the FY 1989 IHS Facilities Construction Budget and, specifically, by removing the Congressionally appropriated funds for the Wagner and Pine Ridge Hospital Projects (both located in the Aberdeen Area Indian Health Service); and,

WHEREAS, The "Resource Allocation Methodology" which the Indian Health Service came out with three years ago was rendered totally ineffective, both internally (within the IHS itself) and politically (via the FY/88 Appropriations Bill), by the Areas and Tribes with the most resources to counteract its intended effect; and,

WHEREAS, In view of the tremendous inequity in resources which persists in the Indian Health Service, major problems in health care service delivery on the Lake Traverse Reservation exist, pending replacement of the Indian Health Service facility which, in accordance with the IHS Facility Construction Priority System process, would be fully staffed, equipped, and adequately funded; and, WHEREAS, On January 22, 1988, the Tribal Council enacted Resolution No. SWST -88-62, which requested that the Indian Health Service prepare and submit a Program Justification Document for a Comprehensive Health Center to be located at Old Agency Headquarters, which would include the following components, as well as the required number of staff, new equipment, and sufficient operating funds:

1. Ambulatory Patient Care (Outpatient)
2. Emergency Room (Level II.)
3. Community Health Services (Dental, Social Services, Mental Health, Health Education, Public Health Nursing, and Sanitation)
4. Administrative Services
5. Staff Housing
6. Space for Tribal Health Programs;

the Resolution further stated that this action was taken "with the understanding that the Tribe does not give up the Hospital or renovation of it and that this action does not exonerate the Indian Health Service from its responsibility for providing funds for running the hospital and clinic"; and it authorized and requested the Indian Health Service and Tribal Administration to proceed with the steps necessary to secure the resources required to provide Tribal members with modern health care facilities and adequate services.

NOW, THEREFORE, BE IT RESOLVED, That the Tribal Council of the Sisseton-Wahpeton Sioux Tribe, supports the recommendation of the Human Services Board, and hereby requests an Congressional inquiry into what actions the Indian Health Service shall take to assure a more equitable distribution of resources so that reasonable trust responsibility will be met at locations like the Lake Traverse Reservation, where there has been no new construction since 1936, where there are chronic budget shortfalls that further limit access to health care, and where the morbidity and mortality rates continue to lag disgracefully behind those of "IHS All Areas" and "U.S. All Races".

AND BE IT FURTHER RESOLVED: That the Tribal Council authorizes the Tribal Executives, Human Services Board, and staff to take all actions necessary to mobilize resouces required to upgrade the Sisseton-Wahpeton Health System.

CERTIFICATION

We, the undersigned duly elected Chairman and Secretary of the Sisseton-Wahpeton Sioux Tribe, do hereby certify that the above resolution was was duly adopted by the Sisseton-Wahpeton Sioux Tribal Council, which is composed of 18 members, of whom 18 members, constituting a quorum, were present at a Tribal Council meeting, duly noticed, called, convened, and held at TiWakan Center, Agency Village, South Dakota, on May 10, 1989, by a vote of 17 for, 0 opposed, 0 abstained, 0 absent from vote, and 1 not voting, and that said resolution has not been rescinded or amended in any way

Dated this 10th day of May, 1989.

ATTEST:

RUSSELL HAWKINS, Tribal Chairman
Sisseton-Wahpeton Sioux Tribe

MICHAEL I. SELVAGE, Tribal Secretary
Sisseton-Wahpeton Sioux Tribe

March 15, 1989 ATTACHMENT A

AO-D

Facilities Construction Priority List

Everett R. Rhoades, M.D.
Assistant Surgeon General
Director, Indian Health Service

This is in reference to the document dated February 21, 1989, regarding the results of the Phase I application of the Priority System. In that memorandum there is an alphabetical listing of projects which will be reviewed in Phase II application of the Facilities Construction Priority System.

Notably, there are no facilities in the Aberdeen Area that will be reviewed. There has been no prior opportunity afforded in which to comment on the projects selected for review in Phase II of this system. My initial reaction to this process was negative. Mr. Pearson has halted the process pending an Office of Health Programs review as a direct result of my intervention.

The importance of this process cannot be minimized since staffing is inherently connected to the construction of health facilities. As health professionals we recognize that our ability to positively affect health problems is dependent upon the level of personnel available. The morbidity/mortality variables in the Aberdeen Area are a clear indication of our unmet needs.

Based upon Resource Requirements Methodology standards, most of the facilities in the Aberdeen Area have a staffing pattern between 30 - 60%. This will not be improved upon unless facilities are constructed within our Area. The most logical approach would be to separate the staffing modules from the Facilities Construction process. I feel that Congress needs to be advised of the serious staffing shortages at various locations within the Indian Health Service system with proposed funding patterns to correct these shortages. Wouldn't it be commendable if, in fact, the Indian Health Service could place a facility at Rosebud with no additional personnel required except in facilities maintenance? The fact is, to bring Rosebud into the modern health care era, we are having to add 140 FTE's, meaning that for the past ten years they have been deficient by 140 FTE's.

Surname	Date

I would request that serious consideration be given to separating the necessary staffing increases required within the Indian Health Service from the Facilities Construction process. I would further request that serious consideration be given to not requesting additional facilities construction until the personnel staffing levels can be brought to an appropriate level. This would, perhaps, require additional construction of quarters at remote locations. I know this would be a drastic step and I state it with a great deal of caution. However, if that cannot be done then I must emphasize that the Aberdeen Area should have a number of facilities on the Facilities Construction Priority List based upon antiquity and lack of appropriate staffing to achieve an appropriate level of success.

I would await your advice on these comments.

Terrence W. Sloan, M.D.
Director
Aberdeen Area Indian Health Service

cc: All Tribal Chairmen
Mr. B. Pearson, Associate Director
Dr. J. Porvaznik, Associate Director, Office of Health Programs
All Associate Directors

WE SUGGEST THE FOLLOWING FORMULA =

$$\frac{(\text{SPACE REQ.})-[\text{AGE ADJ.SPACE} - \text{COND. ADJ. SPACE}]\text{X}\dfrac{\text{REQ. SPACE}}{\text{AGE ADJ. SPACE}}\text{X}(\text{STAFFING FACTOR})\text{X}(\text{ISOLATION FACTOR})}{100} =$$

PRIORITY SCORE.

EXHIBIT A

JUNE 1989 REVISION

Table C
Age Adjustment Factor Table

* Age of the Existing Facility*	0	25	30	35	40	45	50	55	60
Percent of Existing Space to be Used	100%	95%	90%	80%	70%	60%	50%	25%	0%

* The age of a facility for the HFCPS is determined by the date of construction. If additions were made to the facility, then the age is determined by the space which contains at least 50% of the total space. For IHS facilities use the Public Health Service Real Property Inventory to obtain this information. For non-IHS facilities provide documentation on the age of the existing facility.

Affect of Age of Facility
On the Existing Space

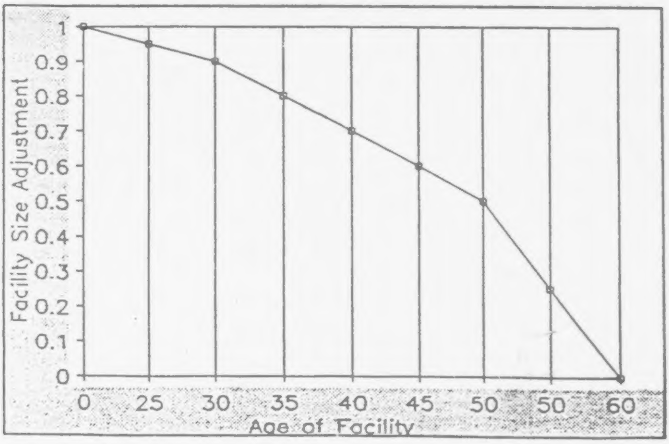


EXHIBIT B

JUNE 1989 REVISION

Table B
Weighting Factor For
Isolation of Populations
Where Outpatient Facilities are Proposed

Miles to Nearest Location where Level I, II, or III Emergency Services are Available:	1 – 25	26 – 35	36 – 45	46 or more
Adjustment Factor	1.00	1.05	1.10	1.15

RECOMMEND REVISION TO THE ABOVE

Miles to nearest location where Level I or II Emergency Services are available:	1 - 25	26 -35	36 - 45	46 or more
Adjustment Factor	1.00	1.15	1.30	1.45

EXHIBIT C

JUNE 1989 REVISION

HEALTH FACILITIES CONSTRUCTION PRIORITY SYSTEM

CURRENT FORMULA

$$\frac{\text{REQ'D SPACE}-((\text{EXISTING SPACE} \times \text{AGE ADJ})-(\text{EXISTING SPACE} \times \text{COND ADJ})) \times 1}{100}$$

EXAMPLE #1

$$\frac{(100{,}000-((80{,}000 \times .95) - (80{,}000 \times .20))) \times 1}{100} = 400$$

EXAMPLE #2

$$\frac{(60{,}000 - ((40{,}000 \times .95) - (40{,}000 \times .20))) \times 1}{100} = 300$$

BOTH FACILITIES ARE 20,000 SQ. FT. DEFICIENT

EXHIBIT D

SPACE DEFICIENCY ADJUSTMENT (SDA)

$$\frac{\text{Total Required Space}}{\text{Age Adjusted Space}} = \text{SDA}$$

EXHIBIT E

STAFFFING ADJUSTMENT FACTOR TABLE

Level of Personnel	0-20%	21-40%	41-60%	61-80%	81-100%
Adjustment Factor	1.40	1.30	1.20	1.10	1.00

$$\text{Level of Personnel} = \frac{\text{Annual FTE Report Totals}}{\text{RRM}}$$

EXHIBIT F

$$\frac{\text{(6/89 REVISIONS)}\times\text{(SPACE DEFICIENCY ADJUSTMENT)}\times\text{(STAFFING FACTOR)}\times\text{(ISOLATION FACTOR)}}{100} = \text{PRIORITY SCORE}$$

Warm Springs, Oregon 97761 / 503 553-1161

TESTIMONY OF THE CONFEDERATED TRIBES OF THE WARM SPRINGS RESERVATION OF OREGON
submitted to the
SENATE SELECT COMMITTEE ON INDIAN AFFAIRS
OVERSIGHT HEARING ON I.H.S. FACILITIES & RURAL HEALTH
MARCH 22, 1990

Access to quality health care for rural populations is a principal concern of the Confederated Tribes of the Warm Springs. A major barrier to access in our community is the lack of an adequate health facility.

Our Tribe was frustrated by the Indian Health Service's lack of progress in meeting the obligation to complete essential health facilities in a timely fashion. Therefore, we brought forth a proposal to implement a joint venture to finance a new Health and Wellness Center on our Reservation. We still do not know the outcome of this proposal, but we believe the notion of joint ventures offers a great deal of potential for Tribes and could conceivably be a mechanism to improve health services to an entire region of rural population.

Our proposal, briefly summarized, is that the Tribe will plan, design and build the new health facility at Warm Springs and provide it rent free to the Indian Health Service for a number of years. In consideration, the Indian Health Service will provide the equipment, a staffing package and its share of the operation and maintenance costs.

The Tribe has attempted to make this proposal as attractive as possible to the Federal Government. We expect to invest over $5 million of our own funds in the facility. The lost earnings on those funds is several million more. This is an unprecedented offer, and an investment in which the IHS will benefit substantially, both in facility savings and savings in Contract Health care. The staffing we have requested is no more than what is needed for today's service demands.

The existing IHS clinic at Warm Springs was constructed in 1934 as a BIA hospital. Although renovations have been made throughout the years, the building is totally unsuited for today's health and wellness program. The facility is too old, too small, too expensive to renovate, and the staff is inadequate for the growing service demand. A replacement facility is urgently needed. At the current pace of IHS construction, it will be well into the next century before we might see a new IHS built facility at Warm Springs.

We simply cannot afford to wait. The health status in our community is unacceptably poor. For example, our average age of death is 44, as compared to 75 in the state of Oregon. We have a hospitalization rate of twice the national average. Birth rates are two to three times that of the surrounding area. Costs of health care are rising at an alarming rate, and both the IHS and the Tribes are heavily impacted. The Tribe is presently funding 37% of the health care expenditures in our community while IHS is funding 49%. Given medical inflation and population growth, we must work together to achieve health improvement.

The Warm Springs Tribes want Congress to realize that this new Health and Wellness Center is an important part of our health improvement plan, but by no means the total answer to the health problems faced by our community. The Warm Springs Tribes have made a large financial commitment to health promotion and disease prevention activities. We have a stated goal of becoming the "healthiest Indian community by the year 2000". Our investments in the health of the community are taking place on four tracks:

1. Development of a responsive health delivery system.
2. Creation of effective health information systems.
3. Establishment of an informed and active community, and
4. Formation of a well informed and conscientious tribal leadership.

We take "Self-Determination" seriously. We believe that there will never be enough money to treat all the illnesses, and so are committed to a government-to-government partnership in which we do our share in the design and implementation of solutions to health problems.

Access to quality health care is a critical element of any community's needed infrastructure and makes economic development and greater self-sufficiency possible. Additionally, community pride is enhanced by ownership and involvement. Our facility will be a symbol to underscore our belief in each individual's responsibility for his/her own health, in that every member of the Tribes will be part owner.

We believe that the Federal Government can better provide for the hundreds of needed facilities in Indian country by leveraging the Federal resources wherever possible. We believe that we have an exciting alternative to 100% Federally financed IHS construction projects. We recognize that there are many Tribes without resources of their own. But we believe that many other Tribes can and would participate, given the incentive and opportunity to do so. Government guaranteed loans, municipal bonds and private financing could all be alternatives to Federal government financed health facilities.

We have conscientiously attempted to minimize the Federal costs associated with this project. We believe it is more than fair, and hope the Congress will accept it. It is crucial that we move as quickly as possible. Each year of delay will cost more, not only in escalating construction costs, but also in increased contract care for both I.H.S. and the Warm Springs Tribes.

A full briefing booklet is available for your review. The briefing includes the background, motivation, details of the proposal, schedules and timing, costs to the Warm Springs Tribes and the Federal government, and a discussion of the advantages and disadvantages to each party.

We come to you today not to complain about the current situation, but to share with you an idea we have to improve our health status. We believe that joint ventures have applicability and policy implications that reach far beyond our community. The Federal government's role is to help communities help themselves. Joint ventures offer a real potential to leverage scarce Federal resources.

We realize that the Nation has constantly struggled with this problem and it seems the solutions continue to be elusive. Indian Tribes are very interested in this effort because our populations represent some of the most isolated and needy groups in rural America. Your committee is to be commended for surfacing this issue and providing a forum for discussion.

Thank you.

THE CONFEDERATED TRIBES OF THE WARM SPRINGS RESERVATION OF OREGON

BRIEFING PAPER

The Warm Springs Tribal Health and Wellness Center Proposal

Table of Contents

Introduction 1

Background
    History of proposal 5
    Motivating factors behind Tribe's proposal 6

Description of the proposal 9

Schedule and timing of the project 11

Status of the proposal 12

Details of the agreement 14

Summary of Financial Impacts
    Impacts to Tribe 25
    Impacts to Federal Government 26

Advantages and Disadvantages of the proposal
    To the Tribe 27
    To the Federal Government 29

Conclusion 31

Appendix

1. Project Schedule
2. Cost Estimate
3. Space Allocation Plan
4. Staffing Package
5. Workload Background

INTRODUCTION

The Confederated Tribes have developed a proposal to build a new health and wellness center and to provide it to the IHS, rent free, for a number of years. The Tribe has worked closely with the IHS in developing the IHS report on the feasibility and cost of this proposal, as requested by the Congress. Accordingly, much of the information contained in this briefing has been provided to the IHS and may also appear in the final IHS report which is due to Congress on March 1, 1990. This briefing discusses the Tribes commitment to quality health care, the thinking behind the proposal and the details of the proposal itself.

The Warm Springs Tribe, concerned about its unacceptable health status, has made a large financial commitment to health promotion/disease prevention activities. They have a stated goal of becoming the "healthiest Indian community by the year 2000". Their investments in the health of the community are taking place on four tracks; (1) the development of a responsive health delivery system, (2) the creation of an effective information system, (3) the establishment of an informed and active community and (4) the formation of a well informed and conscientious tribal leadership. The proposed Health and Wellness Center is an important part of the plan, but by no means is it the total answer to the health problems faced by this community.

Motivated by the necessity to continue to improve the quality and quantity of health services and having the confidence in their capabilities, the Warm Springs Tribe decided to undertake this most ambitious project -- the construction of a new health and wellness center. The Tribe believes that the community must become involved in the solutions to the health problems. The Tribe feels that there is no better way to emphasize that point than with a new facility that the Tribal members themselves would invest in and own.

The Warm Springs proposal essentially provides that the Tribe would build a new health facility at Warm Springs and provide it rent free to the Indian Health Service for a number of years. In consideration of this, the Indian Health Service would provide equipment and a staffing package of about half of what would be provided if the Federal Government financed the facility.

The new Health and Wellness Center will be 35,166 gross square feet and cost the Tribe an estimated 5.2 million dollars. This investment is being made to improve the health status of the population and to reduce the requirements for health services in the future for both the IHS and the Tribe.

This Tribal solution to the federal budget problem, commits additional Tribal resources to the health effort from a Tribe which is already making a substantial contribution. As far as we know, it is an unprecedented offer by a Tribe and we are appreciative that the Congress has taken an interest. We know that without Congressional direction the IHS could not have considered this proposal, due to the present priority system being utilized.

Congressional commitment to reducing the backlog of needed health care facilities for Indians, as reflected in the Indian Health Care Improvement Act, is responded to by this proposal. While it does not follow the present practice of providing facilities, it involves the exciting concept of attracting Tribal participation in the cost of health care through joint ventures. If health facilities could be financed without federal appropriations, the present backlog of needed facilities could be removed at a much faster rate, resulting in improved health care for Indians. It is therefore responsive to the IHS mission of "elevating the health of Native Americans to the highest possible level."

The Tribe is grateful for the opportunity to discuss our proposal in detail with the IHS and Congress. This briefing describes the history, motivation, and details of the Tribe's proposal. Following are some highlights of the briefing.

History:

The Warm Springs Tribe has been developing its proposal for over three years with continued discussions with IHS and the Congress. Aware of the large backlog of construction projects and the slow pace at which IHS is completing projects, the Tribe felt that it needed to explore all options to expedite the construction of the needed facility at Warm Springs.

Motivating Factors:

The principle motivating factors are the gross inadequacy of the existing facility which is less than one third the needed size by IHS standards, and the unacceptable health status of the community. With hospitalization rates at twice the national average and an average age of death at age 44, compared with age 75 for the State of Oregon, the Tribe is fully committed to changing the conditions now. Waiting indefinitely for an adequate facility in inconsistent with the high priority given this matter by the Tribe.

Description of the Proposal:

The Tribe will provide for the full cost of the facility, which will be built to IHS standards. The facility will be leased to the IHS for $1 per year until the year 2000, or until such reasonable time as the Congress and IHS agree. When a date is established, prevailing GSA rates will be applied. IHS will provide all Group 1, 2 and 3 equipment, a partial staffing package and its share of operations and maintenance of the facility. IHS will occupy 82% of the facility and the Tribe the remaining 18%.

Schedule and Timing of the Project:

The Tribe anticipates seeking approval of its membership by referendum and sign an architectural agreement by May of this year. Their schedule calls for completion of design and bid documents by February 1991, with construction beginning in April of 1991 and be completed January of 1992.

Present Status of the Proposal:

The IHS requires Congressional authorization to commit any resources to acquire new space. Congress has directed IHS to report back on the feasibility and costs of this proposal, which is the subject of a report we worked on with the IHS.

Details of the Agreement:

The briefing provides detailed discussion of the Tribes financing plans, a background on the project plans and project cost estimates. The Tribe plans to build a smaller facility than would IHS but will offer extended hours. Facility design is discussed, including how the facility will accommodate coordination between Tribal and IHS programs and a smooth transition to increased contracting of IHS functions in the future. The Tribe will construct the facility, using its own construction department as the general contractor, and the Tribe will operate, and provide all maintenance and repairs to the facility.

IHS would provide 27 new positions of which 24 would require additional recurring appropriations. Twelve (12) should be appropriated for in FY 1991 and an additional twelve in 1992. IHS would provide for equipment of $1,308,000 of which $169,000 is available in the existing facility. The remainder of $1,139,000 would require a one time appropriation, half in 1991 and half in 1992. IHS's share of the Operations and Maintenance would be $200,000 per year, of which $60,000 is available in the service unit budget. An additional $140,000 would be required annually beginning in 1992.

IHS would transfer the existing clinic and all quarters to the BIA for transfer to the Tribe. The Tribe will give priority to medical personnel for use of quarters.

Costs to the Tribe and IHS:

A detailed financial impact on Tribal and IHS resources is provided to the year 2000, which is the suggested year in which the Tribe would first receive rent.

> **Advantages and Disadvantages to the Tribe and IHS:**
>
> This briefing examines the advantages and disadvantages to both parties. It concludes that, based on the goals of the Tribe and IHS, this is an arrangement that will substantially benefit both parties.

Based on the current priority system, that the federal government would be faced with constructing the facility at Warm Springs in the not too distant future, using federal funds, at a much higher cost. Combining the savings to IHS from the Tribes contribution to the effort with the anticipated health improvement based on the Tribes approach to prevention and wellness, it is investment well worth making for both parties.

The proposal responds to the IHS mission of elevating health status. It is a plan that is consistent with all IHS criteria and standards. It is fiscally responsible in that it minimizes federal appropriation requirements. Above all, it is Tribal Self-Determination at work.

BACKGROUND

A. HISTORY OF THE WARM SPRINGS PROPOSAL

The existing Warm Springs Indian Health Clinic was constructed in 1934 as a (Bureau of Indian Affairs) hospital. Although renovations have been made throughout the years, the building is totally unsuited for today's health program. This fifty-five year old facility has only one third the space needed for today's workload. Remodeling is not feasible due to property limitations and the large cost associated with renovation of such an old facility. The ratio of workload to staff is the highest in the Portland Area. Taking all these factors into consideration, the Tribe believes that a replacement facility is definitely needed.

Many discussions have occurred between the Warm Springs Tribe and IHS over the past three years exploring the possibilities of securing a new health care facility. IHS was not in a position to offer much help, since support of construction is restricted to the top ten facilities on our priority list. The Tribal Council, sensing its responsibility to the community and recognizing the urgency of the situation, presented IHS with four options with varying levels of financial participation by each party. IHS still could not commit resources to any project not on the current priority list, but they were intrigued by the notion of a true partnership in health as proposed by the Warm Springs Tribe. Of the four options, the Tribe eventually decided to pursue the one that would be most costly to them and conversely most advantageous to the Federal Government.

Two years ago the Confederated Tribes of the Warm Springs advanced the proposition that they would be willing to plan, design and construct a new Health and Wellness Center for their community without the use of federal funds. IHS considered this an attractive and interesting proposal, but the Indian Health Service was not in a position to enter into the partnership the Tribe was seeking unless specifically directed by Congress to do so.

The Tribe was not discouraged by IHS's inability to provide an unqualified endorsement and we continued to develop our idea into a more refined proposal. As a demonstration of good faith and commitment, the Warm Springs Tribe invested several hundred hours in staff time and over $25,000 in technical assistance. We hired a consultant to assist us in drafting a Program of Requirements (P.O.R.) which is the document IHS utilizes to guide the architect in the design of a facility. The P.O.R. that was developed by the Tribe complied with all IHS standards and criteria. We also contracted with an architectural firm to provide conceptual drawings, room layouts, a preliminary site plan and a rendered elevation drawing.

In the Spring of 1988, the Tribe discussed this issue with various Congressional staff and provided Congress with a briefing in its written positions on the FY 1989 IHS budget. The briefing suggested to Congress that the Indian Health Service seek and explore joint ventures with Tribes so that creative solutions might help eliminate the large backlog of needed health facilities. An abbreviated version of the facility proposal was also provided to Congressional staff at that time.

In the Spring of 1989, the Tribe again brought the issue before the Budget Hearings (F.Y. 1990). The presentation supported the need for a construction priority system for projects totally dependent upon Federal financing. If, however, a tribe is willing to use its resources and talents to finance the facility, then we feel that IHS and Congress should be willing participants in the project.

Both the House and Senate versions of H.R. 2788, the F.Y. 1990 Appropriations Bill for the Department of the Interior and Related Agencies contained report language that requests that IHS work with the Warm Springs Tribe to study our proposal and report back to the Committee by March 1, 1990 on the feasibility and estimated costs of our approach.

B. MOTIVATING FACTORS

In order to fully appreciate the Warm Springs proposal and our high level of interest, it is important to identify the motivating factors that would lead a Tribe in this direction. Like all other tribes we have a thorough understanding of the responsibilities of the Federal Government as they pertain to providing quality health care. Why would we make such a large investment if the principal responsibility for health facilities clearly rests with the Indian Health Service?

Existing facility - inadequate. The existing facility is a poorly designed, overcrowded, unattractive fifty-five year old converted hospital that the community finds unacceptable. There is no choice, however, and the workload is now approaching 30,000 outpatient visits per year. Waiting times are excessive. A facility should be at least 3 times the size of the present building to handle this demand.

An IHS built facility - unlikely for many years. There is no question that there is a need for a new replacement facility. The Indian Health Service has a lengthy list of such projects and the progress in eliminating the large backlog of needed facilities has been slow. Since the Warm Springs Clinic was not on the top ten priority list, the Tribe was discouraged. We realized that it would be well into the next century before we might come to the top of the list at the present rate of construction activity. We concluded that the community could not wait and that we must examine other options for securing a new facility.

Recruitment and Retention of staff - difficult. The recruitment and retention of highly qualified professionals is to a large extent dependent upon adequate facilities, equipment and support staff. Unless something is done in the near term, the Tribe feels it could lose some of their most devoted staff and replacements would be difficult to obtain given the present working environment.

Health status - unacceptable. An unacceptable health status picture is probably the most compelling reason for the Tribe to undertake this project. The average age of death for the past three years was 44. In the State of Oregon the average age of death for the same period was 75. An infant or young child in the 0-4 age group is 3.4 times as likely to die as the young child in the State of Oregon. As adolescents and young adults, the Warm Springs population is 6-7 times more likely to die than Oregon residents in the same age groups. Birth rates in all age groups are 2-3 times those of Oregon. Hospital Admission rates are more than twice the national average. Costs are rapidly accelerating for both IHS Contract Health Program and the Tribal Insurance Program which could result in the rationing of critically needed services. The Tribe has recognized the current conditions and are taking decisive actions to change them.

Health improvement - a Tribal priority. Health care occupies a prominent position among tribal priorities and consequently tribal management has been most willing to commit staff, time and resources in pursuing the goal of improved health care for its members. The Tribe has set the goal of becoming the healthiest Indian community by the year 2000. Creating wellness is our long term strategy.

Health Services - historically a partnership. The health care program of the Warm Springs Indian Reservation has historically been characterized by a strong Indian Health Service/Tribal partnership. Examples of this partnership include financial participation on the part of the Warm Springs Tribe in such programs as Dental services, Maternal and Child Health, Mental Health, Alcohol Treatment, Health Promotion and Prevention programs and Community Development. Cooperative health-related agreements have been negotiated for several years with a variety of local, state, and federal organizations. The Tribe has also self-insured a large number of its members which has greatly reduced the Indian Health Service financial burden in the Contract Health Services program. Today the Tribe finances 37% of the total health costs, IHS invests 49% and various other programs make up the remaining 14%. The Warm Springs Tribe has a reputation of covering its share of the financial burden regardless of the legal and trust entitlement.

Quality Services - essential infrastructure. The Tribe considers it important to build a strong and self-sufficient community. Access to quality health care is an essential part of any community's infrastructure. It is necessary to attract outside business and quality employees on which to build a strong economic base.

Self-determination - taken seriously. Self-determination is taken seriously in this community. The Tribe believes that there will never be enough money to treat all the illnesses and is committed to a government-to-government partnership in which they share in the design and implementation of solutions to health problems. Success depends upon well conceived plans that are responsive to the community's needs. The Tribe has introduced a health planning process which is based upon total community involvement. IHS has been supportive of the Tribe in developing this community based health promotion strategy.

Linking Services - convenience and efficiency. Tribal health programs which should be linked to the Indian Health Service programs are isolated from the health center because there is simply no room for the staff. This creates a very inefficient and uncoordinated system of care for the community. A new facility would bring programs together that should be coordinating activities and create a more responsive health delivery system for the community.

Community needs - must be incorporated. The Tribe would like to see a facility with extended hours that is more responsive to the needs of the community. A large number of Tribal members are employed by the Tribe and its enterprises. Time lost from work for routine health care, dental care and optometric services could be eliminated. The Tribe has plans to build an entire complex, tying together an early childhood development center, an elementary school and the health and wellness center. The long term solutions to the health problems of the tribe revolve around education of this new generation.

Construction costs - escalating. Construction costs are escalating at a 5% per year rate in the Northwest. Interest rates are the lowest they have been for several years. The economy seems to be slowing down, which should be an advantage in attracting the skilled labor required for such a project. It makes good business sense not to delay this project if the Tribe is going to be responsible. Each year the project is postponed adds $250,000 - $300,000 to the Tribe's cost.

Ownership - Community pride. Community pride is enhanced by ownership and involvement. This project will have an emphasis to create a more skilled labor force in the community, which will be needed in the years ahead. Enhancing the skills and capabilities of Tribal members is an important by-product of this construction project.

New approach - benefit to other Tribes. The Tribe believes that other Indian communities would benefit from this approach and Warm Springs would be willing to share their experience and talent with other Tribes seeking to develop facilities without IHS funding.

DESCRIPTION OF THE PROPOSAL

This project should be considered either a joint venture or a true partnership. It is a set of agreements between the Confederated Tribes of the Warm Springs Reservation and the Federal Government that would create a health delivery system to handle the demands of the Warm Springs Community. Congress must authorize the agreement, but the Indian Health Service must implement it.

The following are the conditions of the agreement as it pertains to Tribal responsibilities:

> The Tribe will make available three acres of land for the placement of the facility and the external enhancements.
>
> The Warm Springs Tribe will be responsible for the costs of planning and designing the new facility. This includes the architect and engineering design fee and other costs such as soil analysis and topographical studies.
>
> The Warm Springs Tribe will be responsible for all site preparation items, such as clearing and earth moving.
>
> The Warm Springs Tribe will be responsible for all site improvements such as landscaping, parking, roads.
>
> The Warm Springs Tribe will be responsible for all site utilities such as water supply, sanitary and storm sewer, electrical supply and phone hook-up.
>
> The Warm Springs Tribe will be responsible for the base building construction and associated inspection services. This includes the installation of all Group 1 equipment supplied by the Indian Health Service.
>
> The Warm Springs Tribe will be responsible for the cultural arts of the new facility.
>
> The Warm Springs Tribe will lease the newly built facility to IHS until the year 2000 for $1 per year or until such time as IHS would determine that the Warm Springs Clinic would have been constructed by IHS based upon the Priority system or such reasonable time as can be agreed upon with Congress and IHS. Once a date is agreed upon, prevailing GSA rates will apply.
>
> The Warm Springs Tribe will be responsible for the operational cost associated with the portion of the facility that is occupied by Tribal Staff (18% of the planned facility is devoted to Tribal Health Programs).

The following are the conditions of the agreement as it pertains to the Indian Health Service responsibilities:

> The Indian Health Service shall provide all group 1,2 and 3 equipment in accordance with current standards and provide basic start up furnishings and supplies for the new facility.
>
> > All equipment that is considered usable will be moved from the existing facility at IHS expense.
> >
> > All other required equipment will be purchased with funds provided by IHS.
>
> The Indian Health Service shall provide a minimum staffing package to allow for the workload increases of this expanded facility (A total of 27 new direct service positions are requested to handle expanded hours and increased workload).
>
> > Three (3) positions would be available from existing resources by reprogramming $100,000 that is currently expended in Contract Health Services.
> >
> > Twenty-four (24) additional positions should come from the appropriation process.
>
> The Indian Health Service shall pay operational costs of the new facility (light, heat, phone, housekeeping, minor maintenance, etc) for that portion of the building that IHS staff occupies (82% of the planned facility is devoted to IHS programs).
>
> The Indian Health Service will finance any alterations to the facility that they request over the period of occupancy.
>
> The Indian Health Service will transfer the existing health facility and all office equipment and phone system to the BIA and ultimately it will be converted to Tribal use under the authority of P.L. 93-599.
>
> The Indian Health Service will Transfer the existing housing and furnishings to the BIA and ultimately these units will be converted to Tribal use under the authority of P.L. 93-599.
>
> The Indian Health Service is expected to begin paying rent for the space it occupies in the year 2000 or at a future date agreeable to Congress, IHS and the Tribe. Once the date is established, prevailing GSA rates will apply.

SCHEDULE AND TIMING OF THE PROJECT

Major Events	Date (C.Y.)	Fiscal Year
Tribal referendum	5/8/90	1990
Sign A/E Contract for Design	5/15/90	1990
Approval Schematic Design	7/1/90	1990
Approval Development Documents	9/15/90	1990
Congress appropriates funding for 12 positions and 50% of equipment	10/1/90	1991
Approval Construction Documents	1/1/91	1991
Bids & Awards	3/1/91	1991
Construction start	4/1/91	1991
Equipment selected	6/1/91	1991
Congress appropriates funding for remaining 12 positions, remaining 50% equipment, and IHS O & M costs.	10/1/91	1992
Complete Construction	1/1/92	1992

A more detailed schedule of the project has been included (Appendix 1).

STATUS OF THE PROPOSAL

As pointed out in the background section of this briefing, the Tribes' latest testimony has triggered a congressional inquiry. This document is the Tribe's response to questions regarding the feasibility and costs of this proposal.

The IHS is currently bound by the following congressional directives as pertain to facilities:

Conference Report 95-1672, page 27, September 29, 1978

> "That the Indian Health Service develop and apply a reliable and professional new construction priority system before any additional construction is recommended."

Indian Health Care Improvement Act P.L. 94-437 as amended, page 39, March 29, 1989

> "Sec. 301 (c) The President shall include with the budget submitted under section 1105 of title 31, United States Code, for each of the fiscal years 1990, 1991, and 1992, program information documents for the construction of 10 Indian health facilities which -
> "(1) comply with applicable construction standards, and
> "(2) have been approved by the Secretary.
> "(d) (1)The Secretary shall submit to the Congress an annual report which sets forth -
> (A) the current health facility priority system of the Service,
> (B) the planning, design, construction, and renovation needs for the 10 top-priority inpatient care facilities and the 10 top-priority ambulatory care facilities (together with required staff quarters,
> (C) the justification for such order of priority,
> (D) the projected cost of such projects, and
> (E) the methodology adopted by the Service in establishing priorities under its health facility priority system."

HR-2788 RH Administrative Provisions, Indian Health Service, page 69, line 7-10

> "Provided, that none of the funds appropriated under this Act to the Indian Health Service shall be available for the initial lease of permanent structures without advance provision therefore in appropriations acts:"

In essence there is a stalemate. No matter how attractive the proposal, IHS is unable to commit resources to such a project without the expressed interest and support of the Congress. IHS has no present authority or method to attract or consider proposals for facility construction utilizing non-federal funds.

The Warm Springs Tribe has invested a great deal of time, effort and resources in preparing our plans and we realize that there are no guarantees that Congress will support this project. We are, however, optimistic that our plan will attract a following because it is so unique and represents new thinking in the financing of health centers.

The Tribe is appreciative of the opportunity to fully describe our plan and has worked very closely with the Indian Health Service in preparing the IHS report to Congress. Hopefully, this briefing, along with the IHS report will provide adequate information which will permit the Congress to make a decision regarding this project.

A positive referendum from the population is necessary before the Tribe can make the large capital investment in the facility. That referendum will be prepared and placed before the voters in May, 1990. The Tribe will furnish the results to IHS and the Congress as soon as possible.

DETAILS OF THE AGREEMENT

A. FUNDING THE PROJECT

The funding is proposed as a joint venture - a partnership. It will require a major capital investment by the Warm Springs Tribe for which there will be no financial return for a number of years and there are no guarantees that we will ever totally recover this investment. The Tribe is interested in investing in the health of our their community and this is of greater concern to us than the financial aspects. Tribal leadership believes that an improved health status will result from this investment and that will be a dividend that will keep paying back to the community.

The property (3 acres) has already been set aside as part of the Tribes long term land use plan.

To date, the Tribe has invested approximately $25,000 in consultant services on the project. Staff time devoted to the project is estimated at $30,000.

The Tribe expects to finance the project ($5.2 million) with both Tribal and borrowed funds. Current financing plans indicate that the Tribe would pay 25% ($1.3 million) of the project capital costs from appropriated Tribal funds and borrow the remaining 75% ($3.9 million). The Tribe anticipates an interest rate of about 8% and expects to retire the debt over 15 years from annual appropriations requiring an additional investment of $449,500 per year. The Tribe has recognized and accepted the size of this investment as well as the loss of potential earnings on funds so expended.

It is anticipated that the facility will be truly a community project and that various community groups will contribute to art, playground equipment, landscape and other special amenities.

IHS is expected to finance all Group 1, 2 and 3 equipment for the new facility.

B. PLANNING THE PROJECT

The Tribe has already invested a great deal of staff time in the preliminary planning of the project. We have worked closely with IHS facility planning staff to assure that the proposed facility will meet the standards of the Indian Health Service. We hired a consultant to draft the Program of Requirements (POR). This document is utilized to provide the architect with the sizing of the various departments and describe program relationships that must be considered in the design.

The Tribe also hired an architect to provide some preliminary planning, cost estimates and schedules for the project. That same architect, who is a specialist in health facilities, will be retained for the design phase of the project. The selection of the architect was based upon a rating similar to the procedure that IHS utilizes. In fact, IHS staff participated in the evaluation.

One of the prime considerations in planning this facility was to create a more efficient and coordinated health delivery program. The Tribe has determined that a number of tribal staff that are closely allied to the IHS clinical program be included in the new facility. It makes good sense to bring programs with close ties together and it should facilitate a smoother transition of the program to Tribal management at a later date:

IHS Nutrition with Tribal W.I.C.Program

IHS Community Health Nursing with Tribal M.C.H. and C.H.R.Program

IHS Contract Health Services with Tribal Insurance Program

IHS Clinical Services with Tribal Health Education and Promotion

IHS Administration with Tribal Health Department Administration

The Program of Requirements details these planning assumptions and the architect will design the facility accordingly. Traditionally, IHS built facilities also accommodate these types of arrangements.

The size of the facility (35,166 gross square feet) is somewhat smaller than that which would be constructed using IHS criteria. The initial POR was projecting approximately 43,000 gross square feet. The Tribe has planned their facility so that it would be open for extended hours and offer special clinics on Saturday mornings. Since the projected workload would be spread over more time, the size of the building can reasonably be reduced by 8,000 gross square feet. The Tribe worked closely with IHS planners in making these adjustments. The Tribe has provided both the initial POR and an adjusted POR to the IHS.

We know that the IHS has had limited success with extended hours at other locations. However, the Tribe employs the majority of the work force on the reservation and can directly impact, through employment policies, the effective use of the extended hours.

C. PROJECT COST ESTIMATES

The Warm Springs Tribe can construct the facility for less money than if it were done by the government.

IHS applied its Hanscomb Estimating Methodology to this project utilizing the Tribe's timetable for design and construction. A total of $7,803,000 would be required for this construction project. This 35,166 gsf. facility would cost the IHS approximately $220 per square foot. If this facility was built on the basis of the original Program of Requirements, without considering the extended hours, the project would come to over $9,500,000.

The Tribe's estimate for design and construction and all related work is $5,137,000. Equipment supplied by IHS would add another $1,190,000 to the project, bringing the total cost to $6,327,000. (Full detail of the cost estimates are provided in Appendix 2.)

The difference between a similar sized Federal project and this Tribal project amounts to almost $1,500,000 or approximately a 20% savings.

The Tribe cites several explanations for this difference. First, federal projects require strict conformance to the Davis-Bacon Act. In this case, the Tribe will be able to utilize its own established wage rates. The Tribe is also taking full advantage of its own construction department and special subsidized employee training programs operated by the Tribe. The extensive government reviews of federal projects extends the design phase and adds to the cost of the project.

D. DESIGNING THE NEW FACILITY

The design phase will commence on 5/1/90. The schematic design is scheduled for completion by 7/1/90. The design development documents are programed for completion by 9/15/90. The construction documents and final construction cost estimate will be available on 1/1/91. Bidding and awards will be completed by 3/1/91.

The Tribe has put forth a very ambitious schedule. It will require a great deal of coordination and cooperation to complete the project as planned. The IHS generally allows a full year for the planning and design of a facility of this size. Much of the difference can be attributed to the IHS review and approval process.

The Tribe has requested that IHS facility planning staff participate in the design and plan reviews. With the approval of Congress, IHS could provide the technical assistance that is requested by the Tribe. The involvement of IHS will be much more limited than their usual projects, but the Tribe is interested in IHS input at all stages of the project.

The Tribe has also contacted the State of Oregon to determine what assistance can be provided in terms of plan review and inspection services. The state has indicated that upon request they would participate in review of plans and facilities should IHS not be able to provide the oversight.

The Tribe plans to compete for an energy efficiency grant from a consortium of local utilities. If their architect is successful, it would offset approximately $250,000 of construction costs.

E. CONSTRUCTING THE NEW FACILITY

The Tribe operates their own Construction Department staffed by two engineers and a construction superintendent. We also have contacted a former IHS facility manager to advise us on the project.

The Tribal Construction Department will serve as the General Contractor for the project. All sub-contracts will require three bids and will stipulate that the Tribe's labor force be utilized to the extent possible.

A construction superintendent will be responsible for the management of the entire project by coordinating all construction work from beginning to end.

The Tribes' Construction Department and subcontractors will utilize trainees subsidized by Tribal and State resources, coordinated through the Tribes' training department.

Our Construction Department has had a great deal of experience in constructing major facilities over the last several years, including the Warm Springs Detention Facility, BIA Headquarters projects, and major housing subdivisions.

F. OPERATING THE NEW FACILITY

The Health and Wellness Center contains both IHS and Tribal Programs. IHS programs will take up 82% and Tribal programs will occupy 18%. There is 10,644 square feet of common area that will be divided in the same proportions (Appendix 3).

The Tribe will cover operational costs for its portion of the building. IHS is expected to contribute a fair share in proportion to its occupancy. A direct billing will be provided to IHS on a monthly basis.

An itemization of costs was prepared by a Value Engineer hired by the Tribe (Appendix 2, page 4). The total operation and maintenance requirements for this facility are estimated at $6.93 per gross square foot. The total cost (1992) for 35,166 gross square feet will be $243,700 per year.

Based upon the occupancy of the proposed facility, IHS would be financially responsible for $200,000 per year, which represents 82% of the total. The Tribe would be responsible for $43,700 or 18% of the total.

These figures will eventually be converted to costs for assigned net space to comply with GSA procedures. Total costs will not vary but the denominator will change. In order to arrive at the final negotiated rate, actual measurements must be made when the facility is complete and occupied.

Appropriations generally do not account for these increases even when IHS builds the facilities; they are absorbed by the Area. In this case, the funding should be added so that the Tribe is assured they will receive these costs on an on-going basis.

The Service Unit budget currently includes $60,000 for operation and maintenance. This amount will be available to offset part of the requirements. The need for appropriations therefore will be $140,000 per year. The Tribe has requested that an escalation clause be written into the agreement that would allow modest increases based upon the Department of Labor Consumer Price Index (Class C-All urban consumers). This is the customary method of providing estimates for escalating costs and assures the Tribe of adequate compensation for operations and maintenance.

Should occupancy rates change as a result of the Tribe assuming more of the program via 638 contracting, the billing to IHS will be adjusted accordingly.

G. STAFFING THE NEW FACILITY

The Tribe has looked at staffing and has been very reasonable in terms of the additional positions we propose. If IHS criteria were applied, the resource requirements would be 47 additional positions for the usual 8 year planning horizon. The Tribe has carefully evaluated each department and feel we could satisfactorily operate the facility with an increase of 27 positions. There would be a request to reprogram some contract health service funds to cover three of those positions, since we would anticipate some reduction in contract health services. The remaining 24 positions should be newly appropriated. Their request is approximately 50% of the Resource Requirements Methodology. The staffing table describing resource requirements, available positions, additional required and additional requested by the Tribe has been included (Appendix 4).

It has been suggested by the Tribe that 12 positions be available in F.Y. 1991 to begin the new schedule of expanded hours in the old facility. It would make for a smoother transition when the new facility is open and also provide staffing relief to the heavy existing workload. (Appendix 5) The average cost of a position for IHS is estimated at $31,700 for F.Y. 91. Consequently, the total appropriations for staff in F.Y. 1991 would be $380,400. The other 12 positions and the reprogramming of Contract Health Services should follow in F.Y. 1992. The estimated cost of an average IHS position in F.Y. 1992 is 33,100. Therefore, an additional appropriation of $397,200 would be necessary in F.Y. 1992.

Additional staff that may need to be added in the future, will come from collections and the programs competitive status for IHS funds via the resource allocation methodology.

With a well equipped new facility, and operating costs funded by appropriations the Tribe envisions that all the P.L. 94-437 collections could be dedicated to the expansion of staff as demand increases. This is our plan for future growth, which reduces the staffing requirement called for by IHS standards.

H. EQUIPPING THE NEW FACILITY

The Tribe has made a conscious effort to minimize the requirements for federal appropriations for equipment. We believe we have done a very thorough job of analyzing equipment needs. We have utilized the IHS latest standards to determine each piece of equipment needed. Together with IHS Service Unit Staff they have also inventoried all existing equipment to determine if it can be moved over to the new facility.

The Tribe has provided a complete equipment list to IHS that identifies the item, the department, the room, the quantity, the unit cost, the total cost and whether or not the item is available. This list has been reviewed by IHS and is in conformance with their standards.

The total equipment requirement is estimated at $1,308,000 . It is based upon the latest IHS price lists and has been inflated by 7% to account for estimated price changes that will occur over the next two years.

The total value for the items considered transportable to the new facility is $169,000.

This leaves a need in appropriations for $1,139,000. The construction schedule is such that 50% of the equipment (built in or contractor installed) is needed in F.Y. 91 and the remaining equipment can be purchased in F.Y. 92.

From a tribal standpoint it is important that IHS retain ownership of equipment, because of attractive G.S.A. contract prices. Since IHS is the prime user of this equipment, the Tribe feels that IHS should be responsible for maintaining and replacing it as necessary. Much of the medical & dental equipment has a 5 year life span, due to general wear and new technology becoming available. Repairs and replacements can most economically be handled by IHS. Any additional equipment requirements can be financed by collections.

I. REPAIRS AND MAINTENANCE

The Tribe will assume responsibility for all maintenance and repairs on the building. Should IHS request any alterations to the facility during their occupancy, IHS is expected to finance the changes.

The Tribe's strategy has been to construct all their facilities with similar heating, ventilation, air conditioning, security, mechanical and electrical systems. This has resulted in reduced maintenance costs for all facilities. Our maintenance staff need not become expects on a great number of different systems.

J. LEASING CONSIDERATIONS

The tribe is interested in making this offer as attractive as possible to the government. We will negotiate a lease at $1 per year until the year 2000 or at such time as a new Warm Springs facility would have been built by IHS under the Priority system.

When the government begins to cover rent, it is anticipated that the prevailing GSA rates will apply. It is important to the Tribe, in their financial planning, that a date be agreed upon with the IHS and the Congress.

If IHS were to lease this facility today, the estimated cost of the lease would be $236,400 per year, or $12 per net square foot. This is based on the average rate of return on like investments in the area.

K. TRANSFER OF EXISTING FACILITIES

After the new facility is constructed, IHS would have no use for the existing health center. The Tribe feels it can be utilized very efficiently for our Natural Resource Department, which is very short on space.

The Tribe will be responsible for remodeling that will be necessary to convert the facility to another use. The Tribe requests that the old office equipment and the phone system remain with the old facility. This will require the IHS to declare the property in excess.

Most of the office equipment in the existing facility is old and the Tribe wants to furnish the new facility with new and compatible office equipment.

The medical and dental equipment that is not moved to the new facility would be available to other IHS locations or be declared in excess.

An asbestos removal program currently under way at the facility will ensure the Tribe that the building contains no known harmful substances.

The housing units belonging to the IHS should also be transferred to the Tribe at this time, since IHS will be operating no other facilities on the reservation once the new facility is occupied. Operating and maintenance of the housing can be better addressed by the Tribe. The Tribe has assured IHS that medical personnel will be given priority for the housing units.

SUMMARY OF FINANCIAL IMPACT TO THE TRIBE

The following table reflects the additional investment which would be made by the Tribe for the next ten years under the proposal.

Dollars by Fiscal Year (in thousands)

ADDITIONAL INVESTMENTS REQUIRED:	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	TOTAL
CAPITAL COSTS: FACILITY	505	3,958	487								4,950
EQUIPMENT INSTAL.		250									250
INTEREST DURING CONSTRUCTION			75								75
BOND COUNSEL - LOAN FEES		100									100
LESS: BORROWING		(3,338)	(562)								(3,900)
NEW STAFFING											
DEBT SERVICE			449	449	449	449	449	449	449	449	3,592
NEW OPERATIONS AND MAINTENANCE			96	100	104	108	112	117	122	127	886
TOTAL	505	970	545	549	553	557	561	566	571	576	5,953
Lost Earnings		50	153	222	299	385	479	583	698	825	3,694
Total Cumulative Costs											9,647

NOTES: (1) Estimates include 4% annual inflation on costs from 1993 forward. (2) The Tribe follows practice of setting aside in reserve 1% of Capital costs each year to provide for major repairs to buildings. This amount is included in the Tribes share of new operations and maintenance. (3) Lost Earnings are calculated at 10% of the cumulative investment for prior years. The Tribe is presently receiving about 8% average return on funds invested by the Bureau of Indian Affairs, in trust, and in excess of 12% on funds managed commercially.

SUMMARY OF FINANCIAL IMPACT TO THE FEDERAL GOVERNMENT

The following table reflects the additional investment which would be made by the Federal government for the next ten years under the proposal.

Dollars by Fiscal Year (in thousands)

ADDITIONAL INVESTMENTS REQUIRED:	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	TOTAL
CAPITAL COSTS: FACILITY											
EQUIPMENT		570	569								1,139
INTEREST DURING CONSTRUCTION											
BOND COUNSEL - LOAN FEES											
LESS: BORROWING											
NEW STAFFING		380	794	826	859	893	929	966	1,004	1,045	7,696
DEBT SERVICE											
NEW OPERATIONS AND MAINTENANCE			140	146	151	157	164	170	177	184	1,289
TOTAL		950	1,503	972	1,010	1,050	1,093	1,136	1,181	1,229	10,124

NOTES: Estimates include 4% annual inflation on costs from 1993 forward. No lost earnings have been calculated for the IHS on these additional investments, because they would be offset by factors which are not calculated. First, any savings in charges for contract health services would accrue to IHS. Second, IHS would avoid inflation on eventual construction costs.

ADVANTAGES AND DISADVANTAGES OF THE PROPOSAL

ADVANTAGES TO THE TRIBE

1. A new facility, well equipped with increased staffing would be available within 2-3 years as opposed to waiting for 10-20 years.
2. A major improvement in health status is anticipated. Health promotion/disease prevention activities would significantly increase with additional staffing.
3. Services, currently not available, would be delivered from this new facility. (optometry, audiology and various specialty care).
4. Expanded hours of service would be made available in the community.
5. Consolidation of programs would improve the coordination and efficiency of services.
6. The old health center could be utilized by other tribal programs to reduce the current space shortages.
7. Recruitment and retention of quality clinical staff would be easier.
8. The project will provide jobs and job training. The multiplier effect on other tribal businesses will improve the economy of the entire community.
9. Cost of borrowing is expected to be lower than it has been for some time. Inflation is still under control. A softening economy will create a competitive labor force. From a business standpoint, the timing is good to invest in construction.
10. Community participation promotes the notion of individual responsibility for good health and a reduced dependency on the federal government.

DISADVANTAGES TO THE TRIBE

1. The project will require a large capital outlay that may never be recovered.

2. Tribal funds could have earned nearly $4 million, in lieu of this investment which will produce no financial return for a number of years.

3. There will be an additional burden to Tribal Management as the project develops and a financial responsibility to maintain and service the new facility in the years ahead.

DISCUSSION

The Tribe would benefit substantially in terms of improved services and consequently, health status should be positively affected. There is a large cost associated with this project. Not only does the Tribe provide a large outlay, but it also loses revenue it would have received from investing these funds. The Tribe feels that this investment must be made to benefit their community and to achieve their goal of becoming "the healthiest Indian community by the year 2000". We realize we could wait, and eventually the Federal government would provide the funds for this project. However, we do not feel that the community can afford any further delays.

ADVANTAGES TO THE FEDERAL GOVERNMENT

1. This proposal is most responsive to a goal of IHS - To involve tribes more fully in the management of the programs serving their community (Self - Determination).

2. It is a true government to government relationship in which both governments participate financially.

3. The current financial condition of the federal budget, coupled with the large backlog of needed facilities, begs for innovative solutions to these obligations. We believe that the Warm Springs solution is innovative.

4. The existing facility would eventually be replaced by IHS at a much higher cost. This Tribal investment avoids that future cost.

5. The government would not be required to maintain the facility.

6. The Tribe can build the facility at less cost and in a more timely fashion than IHS.

7. Recruitment and Retention of government staff will be improved by having a well staffed and equipped facility.

8. The new project should reduce future CHS costs by creating a healthier population and replacing expensive hospitalization and emergency room services with more cost effective ambulatory care.

9. The federal debt service on any new facility built by IHS would probably average over 8% per year. The Tribe will absorb this cost for ten or more years.

10. GSA is currently looking at new ways of financing facilities in lieu of one time appropriations. Ideas such as this might encourage others and help to reduce the large backlog of needed facilities.

11. The case can be made that communities, not the federal government, should own their facilities. This proposal takes IHS out of the real estate business at Warm Springs.

12. Taking advantage of non-federal resources is in the best interest of the federal government.

DISADVANTAGES TO THE FEDERAL GOVERNMENT

1. This project as proposed will require a one time increase in appropriations of $1,139,000 for equipping the facility.

2. This project as proposed will require a recurring increase of $380,000 in FY 1991 and another 397,000 in F.Y. 1992 to cover additional staff. There will also be an increase in operating costs of approximately $140,000 per year.

3. This project may set a precedent that will require IHS and Congress to respond to similar proposals. That being the case it will require another set of criteria different from the current priority system to evaluate merit.

DISCUSSION

Eventually, IHS would have to support this project at a much higher cost, using-federal funds. There is no question that the Warm Springs Facility would become a priority of the Indian Health Service. The new priority system methodology which has yet to be adopted will improve the Warm Springs ranking. The new system accounts for the age of their facility which would raise it as a priority because it is so old. Also there has been a significant increase in the workload at Warm Springs since the current ranking was performed. Last years visits were over 29,000, compared with 23,000 visits reflected in the current priority system. Workload is a major driving variable in both new and old systems.

With the large backlog of needed health facilities, (over 100 ~~are~~ now competing for the priority system) finding alternative financing arrangements could prove beneficial to the federal government and Indian tribes in general.

CONCLUSION

We believe our proposal provides an exciting alternative which could have a substantial impact on the availability of quality health facilities and care to Indian people. In terms of Self-Determination, this proposal reflects not only participation in the planning, conduct and administration of the health delivery system, but also a substantial financial commitment on the part of the Tribe.

It will require the Indian Health Service to develop a criteria for responding to such projects outside the existing priority system, but this seems a small price to pay to take advantage of non-federal resources in building a quality health delivery system.

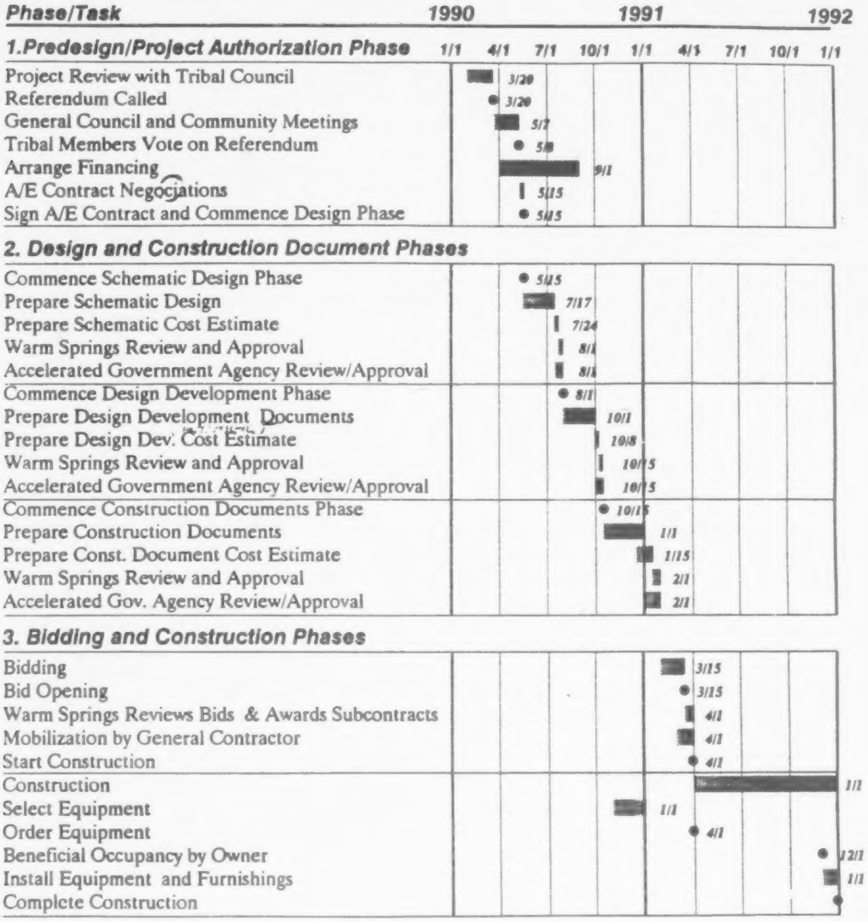
This proposal, with its' heavy emphasis on prevention, health promotion, community involvement and individual responsibility offers a real opportunity to successfully attack the high cost of poor health and required health care. This Tribe has a clear understanding of the complexities of health issues, and has developed a multi-faceted approach to dealing with them. If we are successful, it will demonstrate potential for other communities.

This plan that has conscientiously attempted to minimize the federal costs. The rent free feature, the careful inventory of existing usable equipment and the modest staff increase all demonstrate fiscal responsibility.

We hope to receive Congressional support of this proposal and are prepared, with Congressional approval, to implement an agreement with IHS as described in this briefing.

Schedule of Work

Warm Springs Health and Wellness Center



APPENDIX 1

Warm Springs Health and Wellness Center Proposal

Project Cost Estimates

Annual Operation and Maintenance Costs

Parametric Cost Evaluation

Appendix 2

WARM SPRINGS HEALTH CENTER - PHASE A　　Project Cost Estimate　　KMD ARCHITECTS & FRANK WHELAN ARCHITECT　　January 9, 1990

DESCRIPTION	QUANTITY UNIT	UNIT COST	TOTAL COST	COMMENTS
TOTAL CONSTRUCTION COST			4,116,821	
FURNITURE & EQUIPMENT				
Group II (moveable) Equipment			175,000	Installation only by contractor of IHS furnished equipment
Group III Furniture			25,000	Installation only by owner of IHS furnished equipment
DESIGN & MANAGEMENT				
Feasibility Analysis			65,000	
Site Survey			1,500	Certified for construction
Soils Investigation			10,000	Test borings
A/E Program Analysis and Preliminary Design	(1% of PCC)		41,168	
A/E Final Design/Working Drawings & Specifications	(6% of PCC)		247,009	
A/E Bidding & Contract Administration	(2% of PCC)		82,336	
A/E Agency Interface	(1/2% of PCC)		20,584	
Radiology Consultant			5,000	
Interior Design	(1.25/gsf)		44,160	
Clerk of the Works			45,000	5,000 per month allowance
Lab Testing and Inspection	(0.5% of CC)		19,985	Concrete cylinders & welds, rebar grading
Reimburseables			50,000	
CONTINGENCIES				
Owner's Contingency (4% of Furniture, Equipment, Design & Management)			33,270	
MISCELLANEOUS PROJECT COSTS				
Attorney Fees			20,000	
Referendum Committee Meetings and Mailings			30,000	
Value Engineering			2,500	
Insurance "All Risk"			8,234	Separate policy by owner
Permits & Plan Reviews			4,117	Life Safety Review only

Cost Planners Inc.

CODE NO.	SYSTEM DESCRIPTION	TOTAL COST	---PARAMETRIC ANALYIS--------			LEVEL 2 SUMMARY	% OF TOTAL COSTS	$/GSF
			MEASURE	UNIT	COST			
0100	FOUNDATIONS					64,030	1.6%	1.82
0110	STANDARD FOUNDATIONS			FPA				
0111	WALL FOUNDATIONS	39,550	1,130	FLF	35.00			
0112	COLUMN FOUNDATIONS & PILE CAPS	24,480	36	NCF	680			
0120	SPECIAL FOUNDATION CONDITIONS							
0126	OTHER SPECIAL FOUNDATION CONDITIONS			FPA				
0200	SUBSTRUCTURE					66,332	1.7%	1.89
0210	SLAB ON GRADE			FPA				
0211	STANDARD SLAB ON GRADE	66,332	33,166	GSA	2.00			
0214	TRENCHES, PITS & BASES			EOP				
0220	BASEMENT EXCAVATION			BCF				
0221	EXCAVATION FOR BASEMENTS			CY				
0222	STRUCTURE BACKFILL & COMPACTION			CY				
0230	BASEMENT WALLS			BWA				
0231	BASEMENT WALL CONSTRUCTION			BWA				
0232	MOISTURE PROTECTION			BWA				
0300	SUPERSTRUCTURE					270,083	6.8%	7.68
0310	FLOOR CONSTRUCTION			UFA				
0312	UPPER FLOOR CONSTRUCTION	11,000	2,000	UFA	5.50			
0315	SPECIAL FLOOR CONSTRUCTION			SFA				
0320	ROOF CONSTRUCTION			FPA				
0321	STANDARD ROOF CONSTRUCTION	56,928	14,232	RA	4.00			
0323	CANOPIES	57,500	2,500	CA	23.00			
0324	SPECIAL ROOF SYSTEMS	141,155	20,165	SRA	7.00			
0330	STAIR CONSTRUCTION			FLT				
0331	STAIR STRUCTURE	3,500	1.0	FLT	3,500			
0400	EXTERIOR CLOSURE					417,730	10.5%	11.88
0410	EXTERIOR WALLS			XWA				
0411	EXTERIOR WALL CONSTRUCTION	176,800	13,600	XWA	13.00			
0412	EXTERIOR SCREEN/GARDEN WALLS			XSW				

CODE NO.	SYSTEM DESCRIPTION	TOTAL COST	---PARAMETRIC ANALYIS-------- MEASURE	UNIT	COST	LEVEL 2 SUMMARY	% OF TOTAL COSTS	$/GSF
0415	EXTERIOR SOFFITS	700	100	XSA	7.00			
0420	EXTERIOR DOORS & WINDOWS			XDWA				
0421	WINDOWS	200,000	8,000	XGA	25.00			
0423	EXTERIOR DOORS	40,230	894	XDA	45.00			
0500	ROOFING					183,240	4.6%	5.21
0510	ROOFING ASSEMBLY							
0501	ROOF COVERING	130,720	34,400	RA	3.80			
0503	ROOF INSULATION & FILL	44,720	34,400	RA	1.30			
0504	FLASHING AND TRIM	7,800	1,950	RLF	4.00			
0505	SKYLIGHT AREA			SKA				
0600	INTERIOR CONSTRUCTION					606,681	15.2%	17.25
0610	PARTITIONS			PSF				
0611	FIXED PARTITIONS	164,800	41,200	PSF	4.00			
0614	COMPARTMENTS & CUBICLES			CBCLE				
0616	INTERIOR DOORS & FRAMES	75,000	150	IDL	500			
0620	INTERIOR FINISHES							
0621	WALL FINISHES	83,000	83,000	WFA	1.00			
0622	FLOOR FINISHES	111,300	31,800	FFA	3.50			
0623	CEILING FINISHES	49,500	33,000	CFA	1.50			
0630	SPECIALTIES			GSF				
0631	GENERAL SPECIALTIES	17,583	35,166	GSF	0.50			
0632	BUILT-IN FITTINGS	105,498	35,166	GSF	3.00			
0700	CONVEYING							
0710	VERTICAL TRANSPORTATION SYSTEMS			STP				
0800	MECHANICAL					654,066	16.4%	18.60
0811	PLUMBING	153,600	96	FXT	1,600			
0812	MEDICAL GASES	44,200	17	OUT	2,600			
0820	HVAC	400,000	100	TON	4,000			
0830	FIRE PROTECTION	56,266	35,166	AP	1.60			
0900	ELECTRICAL					421,992	10.6%	12.00

PRORATION OF SPACE

HEALTH & WELLNESS CENTER

The space planned for the new health & wellness center totals 35,166 gross square feet including a 500 square foot garage. The majority of space will be occupied by IHS programs, but several tribal programs will be included in the new facility. The proration of space is important to arrive at operation & maintenance costs for each party. The Tribe hopes to arrive at an agreement with the IHS to share the costs of operation, so that each would pay it's fair share of these costs.

Category	IHS(gsf)	IHS%	Tribe(gsf)	Tribe %
Diagnostic	2739	100%	0	0%
Clinical	9949	100%	0	0%
Community* Health	1807	40%	2714	60%
Admin.	2423	68%	1125	32%
Health Rec.	1253	100%	0	0%
Employee Fac. & Training**	1529	76%	483	24%
Subtotal***	19700	82%	4322	18%
Public Fac. Housekeeping Supply Maintenance Building Ser.	5683	82%	1247	18%
Mechanical	3045	82%	669	18%
Totals	28428	82%	6238	18%
Garage	500			

* Community Health Storage & Conference divided 50% each party.

** Employee Facilities divided by total staff (IHS 54.5 staff and Tribe 17.5) Therefore 76% to 24%.

*** Overall program space calculations applied to Public Facilities, Common Use Areas and Mechanical.

Appendix 3

STAFFING SUMMARY

Department or Service	RRM Staff Required	Current Staff	Additional Positions Required	Additional Positions Requested
Laboratory	2.8	1.0	1.8	1.5
Radiology	1.3	1.0	0.3	0.0
Outpatient	15.2	6.0	9.2	8.0
Com. Health Nurs.	4.0	1.0	3.0	3.0
P.H. Nutrition	1.8	1.0	0.8	0.0
Env. Health	1.0	1.0	0.0	0.0
Mental Health	4.7	3.5	1.2	1.0
Health Education	1.4	1.0	0.4	0.5
Dental	15.0	3.0	12.0	5.0
Pharmacy	4.4	2.0	2.4	1.0
Admin. Services	11.0	6.0	5.0	4.0
Health Records	5.0	2.0	3.0	2.0
Property/supply	2.2	0.0	2.2	1.0
Housekeeping	4.1	1.5	2.6	0.0
Maintenance	4.0	1.0	3.0	0.0
TOTAL	77.9	31.0	46.9	27.0

The Tribe has suggested that three positions would be available from current resources in their Contract Health Service Budget. It would require reprogramming $100,000 from Contract Health Services to Hospitals & Clinics. This should be accomplished in F.Y. 1992 to comply with the project schedule.

Appendix 4

Native American
Women's Health Education Resource Center

A PROJECT OF THE NATIVE AMERICAN COMMUNITY BOARD

March 21, 1990

The Honorable Daniel Inouye
and Senate Select Committee Members
UNITED STATES SENATE
Washington, D. C. 20510

Re: Proposed Closure of Inpatient Services
Wagner Service Unit, Wagner, South Dakota

Dear Senator Inouye and Committee Members:

Enclosed is testimony being submitted by the Native American Women's Health Education Resource Center and the Yankton Sioux Tribe, for the Senate Select Committee hearing scheduled for March 22, 1990, concerning the proposed closure of the Wagner Indian Health Service Unit inpatient services.

The documents are:

1. Wagner IHS Proposed Closure Questions & Concerns

2-A. Correspondence: September 8, 1989
To: Honorable Daniel Inouye
From: Dr. Everette R. Rhoades

-B. Correspondence: January 19, 1990
To: Ms. Charon Asetoyer
From: Dr. Everette R. Rhoades

-C. FAX - February 13, 1990
To: Mr. Donald LaPointe
Santee Sioux Tribe
From: Dr. Terrance W. Sloan

3. Correspondence: February 6, 1990
To: Dr. Everette Rhoades
From: Stephen Cournoyer, Jr., Chairman,
Yankton Sioux Tribe

P.O. [illegible] [illegible] 0572 • 605-487-7072

4-A. Yankton Sioux Tribal Resolution #90-11
-B. Rosebud Sioux Tribal Resolution #89-183
-C. Santee Sioux Tribal Resolution # 90-19

5. Correspondence: February 6, 1990
To: Senator Tom Daschle
From: Stephen N. Cournoyer, Jr., Chairman
Yankton Sioux Tribe

6. Memo: April 25, 1989
To: All SUDS
From: AO-CHS

7. Letters of Support & Concern

-A. March 7, 1990
From: Senator Edward Kennedy

-B. January 12, 1990
From: Church Women United

-C. February 27, 1990
National Organization of Women

-D. December 20, 1990
Senator Bill Bradley

-E. March 21, 1990
National Women's Health Network.

-F. March 21, 1990
RCAR Educational Fund

8. REPORT: Current Health Status of the Wagner Service Unit Area
(Yankton, Santee and Rosebud Sioux Reservations)
and the Effects of Indian Health Services Proposed
Inpatient Service Closure

In addition, it must be pointed out that many of the inpatient services, such as deliveries are being contracted out, if deliveries were to return to the Wagner IHS Unit, it would increase the ADPL from 8.9 to 10.3. That is only one example of how contracting out services creates a low ADPL.

Yes, the ADPL is low but that has been created by contracting out certain inpatient services that could very well be done at the Wagner Service Unit, at a much lower cost.

If you were to research the cost of contracting out vs. providing inpatient services you will find that inpatient services are more cost effective. Plus the added benefits of keeping the patient near their support system (family), which can reduce the number of days for recovery.

The distance a patient must travel to contract services should also be taken into consideration. There are also out-patient services that are being contracted out from the Wagner IHS Services Unit which costs could be reduced by having the physicians travel to the Service Unit rather than transporting patients out. It would cut down on travel, lab fees, and the fees paid out for usage of the other facility.

Much of this boils down to proper management by the Service Unit Director.

Please do not hesitate to contact our office at (605) 487-7072 for additional information.

Sincerely,

Charon Asetoyer

Charon Asetoyer, Ex. Director
NATIVE AMERICAN WOMEN'S HEALTH
EDUCATION RESOURCE CENTER.

CA: jr

Enclosures

1.

WAGNER IHS PROPOSED CLOSURE QUESTIONS AND CONCERNS

I.

Dr. Rhoades has made reference to Indian Health Services physicians being privileged to see patients at the Wagner Community Hospital thus eliminating the cost of contract physician services in large measure.

This model presents concerns about even keeping the clinic out-patient services open and infers closing both the inpatient and outpatient services.

It must be noted that the following condition exists at the Wagner Community Hospital:

1) "The only hospital, Wagner Community, that could possibly take out-patients is not JCAHO accredited", until they are, we cannot use their services.

2) "There must be provisions for Indian members to be on the Hospital Board of Directors before we can use the above hospital." It was suggested that two positions be created for Native Americans to sit on the Wagner Community Hospital Board of Directors. The Wagner Community Hospital has agreed to allow one Native American representative to sit on the Board, but the one position would not be allowed to have voting power.

3) "We would ask that the Wagner Community Hospital use Indian preference in hiring before we can utilize their facility." Currently, they have not agreed to this, i.e., as in compliance with the Indian Self-determination Act.

4) "Finally, the bed capacity of the Wagner Community Hospital will not accommodate the Wagner Service Unit patient needs at this time." Over crowding is a likely possibility. In the winter at the Wagner IHS Unit hospital, ADPL is as high as 12. During the same time period at the Wagner Community Hospital, ADPL has been 12 as well.These peak times tend to occur simultaneously in which case not enough beds will be available for all the patients requiring inpatient care. Wagner Community Hospital only has 20 beds. There has also been days during this same time, where the patient daily load has been 20 at the Wagner Community Hospital which means full to capacity. With the Native American population increasing, this will present problems for future hospital availability.

II.

In correspondence from Dr. Rhoades office to the Honorable Daniel Inouye's office dated September 8, 1939, it was stated that the Wagner IHS has 8 births per year. It must be noted that the 8 births were emergency births that did not make the 63 miles that women are transported to Yankton for delivery of their babies. This facility in Yankton is 63 miles away from Wagner at an average cost of $3,500 per delivery of contract health dollars The annual average deliveries is approximately 90 births, totalling approximately 315,000 per year in contract health dollars.

If the Wagner IHS unit reinstated delivery services it would save money and would reduce the potential health risks for both the mother and infants due to the long distances need to transport for delivery. It would seem both cost effective and would reduce health risk to mother and infant to deliver babies at the Wagner IHS unit.

Construction started on the Wagner IHS Unit in 1935 with the first patient coming into the facility in 1937, a structural addition was built in 1965. This facility may seem aged to some although with minimal remodeling could very well be modernized. Remembering that some of the countries most prestigious institutions and medical schools were built prior to 1935.

It must be noted that several communities served by the Wagner IHS Unit are as far away as 48 miles from the service unit, and 112 miles from the Sacred Heart Hospital in Yankton which is usually the nearest contracted facility. During the seven winter months travel is very difficult and hazardous. The usual travel time of 1 hour is increased to 2-1/2 hours, which does pose an increased threat to life (as stated in correspondence, September 8, 1989 from Dr. Rhoades to the Honorable Daniel Inouye).

III.

Another factor that needs to be addressed pending an in-patient closure is the availability of sufficient contract health dollars which at present is insufficient and does not even meet the priority one category of patient eligible payment services.

As stated in the Report, "Current Health Status of Wagner Service Unit Area (Yankton, Santee, and Rosebud Reservations) and the Effects of Indian Health Service proposed Inpatient Service Closure" it states community education and outreach are the most important and appropriate health resources investment in addressing these issues.

However, the Wagner IHS Unit is currently only serving 35% of it's service population. There are 7,244 active files in the Wagner IHS unit, yet in 1988 approximately 2,500 patients were seen at the service unit. Which means the current existing outreach is only servicing a small portion of the patient population with increased outreach targeted at providing services to the total service unit population would justify increases to the base budget.

The increase in providing services to total Service Unit population would also increase the average daily patient load from 5.7 to 17. Thus satisfying the 15 bed minimum inpatient ADPL. This points out that the Service Unit is not reaching it's services population. Considering the poor status of health and the fact that people do need medical attention, this is especially dangerous. Furthermore, the statistics quoted in the letter from Dr. Rhoades dated September 8, 1989, sites statistics from the "Program Justification Document" of May, 1986. The figures of 5.7 ADPL has currently risen to 8.9, which represents an incrase of 41%.

With increased services to reach the total service population additional dollars will be needed for health education and outreach; conversely, more inpatient dollars will be needed to adequately address the identified inpatient population who need inpatient care.

This important consideration was not fully addressed in the January 19, 1990, correspondence to Ms. Charon Asetoyer from Dr. Rhoades, when he stated, ".. funds recouped from the inpatient closure will allow for augmentation of available CHS funds."

IV.

An important aspect that Dr. Rhoades may been remiss in, is Indian Health Services' inherent trust responsibility to health care need of all service populations. Further, the Indian Self-Determination Act mandates Indian involvement in all matters affecting Indian people. Indian Health care needs are matters of the greatest importance to Indian self-determination. The continued funding of an inpatient facility within the Wagner Indian Health Service Unit would insure Indian participation in their health care delivery systems and continued self-determination. Dr. Rhoades' suggestion of utilization of the local community hospital would be inappropriate becasue of the direct conflict with the Indian Self-Determination Act. Due to the on-going suppression of Indian involvement in all areas of organization at the Wagner Community Hospital, Dr. Rhoades' suggested policy is questionable.

V.

If the Contract Health Care Dollars were re-routed back to the Wagner IHS Unit to provide in-patient services such as deliveries, it would provide consistency and continuity in health care, such as in family practices.

Local inpatient services also reduces the risk to patients associated with doctors who are unfamiliar with patient histories, also with the risk of the long distance transportation.

It has also been proven by the medical community that patient recovery time is reduced when a patient has a support system such as family visits. By hospitalizing patients at a considerable distance from their communities, additional hardships are created to the already economically deprived family members who may not have the resources to travel the long distances necessary to visit the family members thus eliminating the patient support system, resulting in longer hospitalization stays.

DEPARTMENT [illegible]

Indian Health Service
Rockville MD 20857

SEP 8 1989

The Honorable Daniel Inouye
United States Senate
Washington, D.C. 20510

Dear Senator Inouye:

This is in response to the letter, dated June 12, from members of the Select Committee on Indian Affairs, which expressed concern about diminishing India access to inpatient care in rural areas. Be assured that the Indian Health Service (IHS) shares your concern and that we are cognizant of the issues raised when policies pertaining to health care delivery and facility construction are developed and implemented.

I pledge full cooperation by the IHS in the Committee's efforts to explore this issue. Accordingly, I have issued the following guidelines to all IHS offices:

> The IHS will delay implementation of the Standard for an IHS Health Care Facility until the Senate has had an opportunity to hold an oversight hearing on this issue later this year.
>
> The IHS will delay implementation of previous decisions regarding discontinuation of inpatient services at Owyhee, Nevada, Wagner, South Dakota, Ft. Belknap, Montana, and Ft. Yuma, Arizona, for the same period
>
> The IHS will temporarily freeze the positions of these four projects on the IHS health facilities priority list, and the funding of these four projects in the IHS health facilities construction program, unless the affected tribe and the IHS mutually agree to proceed with the project under present IHS guidelines.
>
> The IHS will temporarily delay implementation of the revised IHS Health Facilities Priority Methodology until we are confident that the Methodology can be implemented without conflicting with the intent of yo efforts. (We would like to avoid an extended delay since the Congress h indicated previously that we should have a revised methodology ready for implementation this year.)

The IHS is constantly faced with the challenge of providing quality care wit the constraints of limited resources and rapidly escalating medical care cos Therefore, we are compelled to define cost effective approaches to health ca delivery while assuring quality of care to the greatest extent possible. We welcome the opportunity to describe some of our efforts in this regard.

Closure of IHS Inpatient Services: This issue has been the subject of extensive review and study by various governmental components including the General Accounting Office (GAO) and the Office of Inspector General (OIG). : is the substance of the 1982 GAO Report entitled "Opportunity to Avoid Construction at Certain IHS Hospitals," and plans for further review have be included in the "OIG Work Plan for Fiscal Years 1989 and 1990." The latter reviews will describe the OIG's assessment of the potential for cost efficie care provided through community-based facilities rather than IHS facilities. An IHS analysis of this issue found that small hospitals do cost more to operate, are difficult to staff, cannot provide a full range of services and therefore, vary in ability to ensure provision of quality care. The provisi of quality care requires staff proficiency in carrying out procedures and meeting professional standards. This is best assured when there is a reasonable degree of regularity in service delivery/procedure execution by qualified practitioners.

This phenomenon is not unique to the IHS. It applies, as well, to small hospitals throughout rural America. Furthermore, the Joint Commission on Accreditation of Healthcare Organizations and Health Care Financing Administration certification criteria require that certain standards be met specific services are to be provided by a certified facility. In very small hospitals, these requirements often preclude certain kinds of inpatient care such as obstetrics/gynecology and/or surgery.

The IHS concern for the quality and cost of care led to development of the Standard for an IHS Inpatient Facility (copy enclosed). This policy defines minimum standard for inpatient workload. By implementing this policy, the I seeks to ensure access to quality inpatient care either through maintenance an IHS direct care capability or through use of services purchased from the private sector with Contract Health Services (CHS) funding.

4#

When no alternative to ~~the~~ provis~~ion of direct~~ ng local health care exists, as in isolated Alaska villages, the IHS will continue to maintain facilities to ensure inpatient care availability. Any proposed discontinuation of direct inpatie care requires tribal consultation, sufficient CHS funding, and congressional notification. This policy was developed over a 2-year period and was circulated to all IHS Area and Headquarters offices for review and comment o two occasions prior to its incorporation in the Indian Health Manual on June 7, 1989.

Procedures for implementing the policy will also comply with the requirement of Section 301 of Public Law 100-713, "the Indian Health Care Improvement Act," which specifies that the IHS must assess and inform the Congress of th impact of proposed closures. To date, there are only four IHS inpatient services being considered for closure: Wagner, South Dakota, which has an average daily census of 5.7 patients and 8 births per year; Yuma, Arizona, average daily census of 7.2 patients and no births; Owyhee, Nevada, average daily census of 2.1 patients and no births; and Harlem, Montana, average dai census of 4.3 patients and 5 births per year.

The Subcommittee's June 12 letter indicates concern that one of these hospitals was built only a few years ago (probably Owyhee which was completed in 1979) and suggests that poor planning was responsible for its being oversized. With respect to the Owyhee facility, we agree that the patient-load was not sufficient to warrant construction of an inpatient care facility. The determination that a hospital was required there did not originate in the IHS. The Owyhee facility would not have competed successfully with other more urgently needed facilities in the facilities priority determination process, and it would not have been placed on the IHS health facility priority list.

Changing Focus from Hospital Inpatient Services to Ambulatory and Community Health Services: The nature of health conditions among Indian people today requires redirection of IHS services from the health care delivery modes traditionally provided. The prevalence of chronic diseases and of problems associated with lifestyle are preeminent and require community-based planning and the implementation of new, often innovative, prevention and treatment programs.

The IHS position is that health promotion/and disease prevention can best be realized through provision of community-based health services complimented by necessary hospital care. Where chronic diseases such as diabetes exist, epidemiological approaches can be implemented in the local community setting. In this manner, resources and services can be targeted to specific problems and better outcomes can be achieved. This concept requires the development of cooperative partnerships between the IHS and local communities.

Rural Health Policy: We presume that the enclosed Indian Health Manual issuance on Standards for an IHS Inpatient Facility is the IHS rural health policy proposal referenced in your letter. Review of this policy will verify the IHS' intent to ensure continued access to inpatient care for In in rural areas.

Basically the IHS system is rural in nature. Accordingly, much of IHS health policy could be described as a rural health policy; however, the IHS has not defined rural health outside the context of Indian health. Neither have we assessed possible interrelationships with non-Indian rural communities comprehensively.

The Department's current focus on rural health issues will require that IHS assess the status of health care in geographically isolated areas, where tribes and/or Alaska Native communities exist, as well as the impact of the increasing trend toward small rural hospital closures. The IHS agrees with the Committee that this issue should be investigated. We will consider a project to assess the rural health issue in the IHS Office of Planning, Evaluation, and Legislation's "Research and Evaluation Plan for Fiscal Year 1990." Should the IHS decide to fund such a study, the results will be made available to the Congress for review.

A study being conducted by the Office of Health Program Research and Development was referenced in the Committee's letter. Under this study a number of IHS health care delivery issues are being investigated. While some of these issues have potential long-range impact, such as the development of a benefit package, the rural health care issue is not being addressed.

Tribal Consultation: As indicated in the enclosed policy, and in keeping with the requirements of the Indian Health Care Improvement Act, affected tribes will be consulted when any inpatient service closure is proposed. Although there is no formal, established IHS process for consulting with tribes, every attempt is made to include tribal representatives in work group, task force, committee, and other meetings on such matters. In addition, each year the IHS sponsors a national meeting to continue the process of tribal consultation/participation in IHS policy development and program operations planning. Tribal representatives participate in development and execution of the agendas for these meetings. The IHS does recognize the need for a tribal consultation policy and implementing procedures and has undertaken their development.

In summary, the IHS shares your concern that Indians who are eligible for IHS services have access to needed inpatient care. Such access will be available either in an IHS or tribally operated hospital or in an accessible referral hospital. It is our sincere hope that this response provides sufficient information for your immediate use in examining rural health issues as they pertain to the IHS and to Indian people. We stand ready to provide any further information you may require. A similar letter is being sent to the other members of the Select Committee on Indian Affairs who expressed concern.

Sincerely yours,

Everett R. Rhoades, M.D.
Assistant Surgeon General
Director

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20857

JAN 19 1990

Ms. Charon Asetoyer
Executive Director
Native American Women's Health
Education Resource Center
P.O. Box 572
Lake Andes, South Dakota 57356-0572

Dear Ms. Asetoyer:

Thank you for your letter of December 8, 1989, forwarding Yankton Sioux Tribal Resolution #90-11 and the attached report, "Current Health Status of the Wagner Service Unit Area and the Effects of the IHS Proposed Inpatient Service Closure." This document has been reviewed and a number of interesting points noted.

You have done an admirable job of outlining the health issues affecting the population of the Yankton-Wagner Service Unit. In particular, the discussion of health status and the individual diseases is noteworthy. The infant mortality rate is unacceptable as are the number of deaths associated with violence and unintentional injury. But as the Report states, community education and outreach are the most important and appropriate health resources investment in addressing these issues, not continued operation in an aged inpatient facility.

The Report also raises the issue of availability of Contract Health Services (CHS) funds and the availability of quality services from local community hospitals. The funds recouped from the inpatient closure will allow for augmentation of available CHS funds. In addition, it would be my intent that the Indian Health Service (IHS) physicians be privileged to see patients at the community hospital thus eliminating the cost of contract physician services in larger measure. The privileging of IHS physicians would also provide a framework for increased quality assurance activities in the community hospital and facilitate certification by the Joint Commission of Accreditation of Healthcare Organizations. There are many models of successful uses of this strategy throughout IHS, most notably in the Portland and the Oklahoma IHS Areas.

There are a number of other interesting points which would merit indepth discussion with the Aberdeen Area staff and community members. I will not address those issues at this time. I agree with your view that increased discussion of these issues at the community level is critical to the development of an appropriate strategy. I have asked Terrence W. Sloan, M.D., Director, Aberdeen Area IHS to initiate activities to develop such a dialogue.

This is an important issue for the Yankton-Wagner Service Unit and the Aberdeen Area, and has national implications as well. I will continue to monitor the progress of this situation.

Sincerely yours,

Everett R. Rhoades, M.D.
Assistant Surgeon General
Director

BEST AVAILABLE COPY

Mr. Donald LaPointe
Chairman
Santee Sioux Tribe
Niobrara, Nebraska 68760

Dear Mr. Chairman:

I have received Santee Sioux Tribal Resolution #90-10 regarding Indian Health Service closing the inpatient services at the Wagner Service Unit.

I appreciate the concern of the Santee Sioux Tribal Council in looking out for the best interest of their constituents. Please assure the Council that I am in full support of their position.

The Program Justification Document for the Wagner Outpatient Renovation specifies the following conditions to be met before my consideration will be given for closing the inpatient beds:

1. The only hospital, Wagner Community, that could possibly take our patients is not JCAHO accredited. Until they are, we cannot use their services.
2. There must be provisions for Indian members to be on the Hospital Board of Directors before we can use the above hospital.
3. We would ask that the Wagner Community Hospital use Indian preference in hiring before we utilize their facility.
4. Finally, the bed capacity of the Wagner Community hospital will not accommodate the Wagner Service Unit patient needs at this time.

I am forwarding a copy of Resolution #90-19 to Dr. Everett Rhoades, Director, Indian Health Service, so he will be aware of the wishes of the Santee Sioux Tribal Council.

Sincerely,

Terrance W. Sloan, M. D.
Director
Abardeen Area Indian Health Service

cc: V. Donnell, SUD, Wagner
E. Rhoades, MD, Director, IHS

3

YANKTON SIOUX TRIBE
Box 248
MARTY, SO. DAK., 57361
384-3804 / 384-5687

February 06, 1990

Dr. Evertt Rhoades
Director, Indian Health Service
Parklawn Building Room 5A-55
5600 Fishers Lane
Rockville, Maryland 20857

Dear Dr. Rhoades:

Enclosed please find three (3) Resolutions opposed to the proposed closure of inpatient services at the Wagner IHS Unit Hospital.

We do not endorse the proposal for closure. We are grateful that IHS will delay implementation of previous decisions regarding discontinuation of inpatient services at, among others, Wagner, South Dakota

We feel that the actions, if taken, are contrary to the Federal Government's traditional trust responsibility for Indian Health care and that the decision was made and promulgated without the necessary statistics to reflect the accurate picture of our health needs.

Furthermore, we believe that if there is no more direct inpatient services provided by IHS then more patients will have to travel greater distances for contract health care. This can only compromise a population, which is already in a devastated status.

We also encourage further dialogue with you on this issue.

Sincerely,

Stephen N. Cournoyer, Jr.
Chairman
Yankton Sioux Tribe

Enclosures

cc: Senator Tom Daschle, Select Committee on Indian Affairs
Senator John McCain, Select Committee on Indian Affairs
Dr. Terrence Sloan, Area Director, Aberdeen IHS
Mr. Vern Donnell, SUD, IHS, Wagner, S.D.
File

OFFICERS:
STEPHEN COURNOYER, JR.
EVERDALE SONGHAWK
DARRELL DRAPEAU
HARLAN HORNED EAGLE

BUSINESS & CLAIMS COMMITTEE

LOUIE ARCHAMBEAU
WILLARD BRUGUIER
RAYMOND COURNO
KENNETH HONOMIC
EDWARD ZEPHIER, J

YST

H-A

YANKTON SIOUX TRIBE
RESOLUTION NO. 90-11

WHEREAS: The Yankton Sioux Tribe is an unincorporated Tribe of Indians operating under an amended Constitution and By-Laws approved on April 24, 1963, and June 16, 1975; and

WHEREAS: The Yankton Sioux Tribe Business and Claims Committee, an elected body constituted for the purpose of conducting the business of and serving the best interests of the Yankton Sioux Tribe; and

WHEREAS: The Yankton Sioux Tribe Business and Claims Committee has contributed throughout the years to improving the standard and quality of life on the Yankton Sioux Reservation; and

WHEREAS: The Wagner Indian Health Service Hospital serves a patient population of 7,244 people; and

WHEREAS: The Wagner Indian Health Service Hospital service area includes all of the Yankton Sioux Reservation of South Dakota; Santee Sioux Reservation of Nebraska; and Eastern section of the Rosebud Sioux Reservation of South Dakota, and

WHEREAS: The geographic service area of the Wagner Indian Health Service Hospital is 3,714 square miles, which is one-half the area of New Jersey and nearly twice the area of Delaware; and

WHEREAS: Economically, the Wagner Indian Health Service Hospital population is devastated, with an unemployment rate of 85% and the average annual income for a family of four is $4,623, the lowest of any group in the country; and

WHEREAS: The infant mortality rate for the Wagner Indian Health Services Hospital area is 28.8, the highest in the United States; and

WHEREAS: The Indian Health Service has proposed the closure of the inpatient services at the Wagner Indian Health Services Hospital at Wagner, South Dakota; and

WHEREAS: The closure of inpatient services at the Wagner Indian Health Services Hospital would have catastrophic consequences for the health needs of the service population; and

NOW THEREFORE LET IT BE RESOLVED, The Yankton Sioux Tribe opposes the proposed closure of the inpatient services at the Wagner Indian Health Services Hospital; and thereby, directs Indian Health Services to follow it's mission statement which is to ensure equity, availability, and accessibility of a comprehensive high quality health care delivery system providing maximum involvement of American Indians in defining their health needs, setting health priorities for their local areas, and controlling their health problems.

CERTIFICATION

THIS IS TO CERTIFY that the above and foregoing Resolution was approved by the Yankton Sioux Tribe Business and Claims Committee on the 26th day of October, 1989, at a meeting held in Marty, South Dakota, by a vote of 6 in favor, 0 opposed, 0 not voting, 1 abstaining, and 2 absent.

ATTEST

Darrell Drapeau

Stephen N. Cournoyer, Jr., Chairman
Business and Claims Committee
Yankton Sioux Tribe

Darrell Drapeau, Secretary
Business and Claims Committee
Yankton Sioux Tribe

4-B

ROSEBUD SIOUX TRIBE
RESOLUTION NO. 89-183

WHEREAS, the Rosebud Sioux Tribe is a federally recognized Indian Tribe organized pursuant to the Indian Reorganization Act of 1934 and all pertinent amendments thereof; and

WHEREAS, the Rosebud Sioux Tribe is governed by a Tribal Council comprised of District Representatives empowered to act in accordance with the Rosebud Sioux Tribal Constitution and By-Laws; and

WHEREAS, the Rosebud Sioux Tribal Health Board and the Rosebud Sioux Tribal Council, by previous resolution, has placed health as a high priority; and

WHEREAS, Rosebud Sioux Tribal members utilize the inpatient services of the Wagner Service Unit as per Memorandum of Agreement between the Rosebud Service Unit and the Wagner Service Unit; and

WHEREAS, the Rosebud Sioux Tribal Council has been informed that the Indian Health Service has plans to close the inpatient services at the Wagner Service Unit in 1991; and

WHEREAS, the Rosebud Sioux Tribal Council is extremely concerned that with the closing of inpatient services, many of our tribal members who utilize the Wagner Service Unit may be without the proper health care that they need and deserve; now

THEREFORE BE IT RESOLVED, that the Rosebud Sioux Tribal Council completely opposes the Indian Health Service's plans to close the Wagner Service inpatient services at Wagner, South Dakota, in FY-1991; and

BE IT FURTHER RESOLVED, that the Rosebud Sioux Tribal Council supports the Native American Women's Health Education Resource Center in all efforts to keep the Indian Health Service from reducing any health care services at the Wagner Service Unit.

CERTIFICATION

This is to certify that the above Resolution No. 89-183 was duly passed by the Rosebud Sioux Tribal Council in session on December 15, 1989, by a vote of eight (8) in favor, zero (0) opposed and one (1) not voting. The said resolution was adopted pursuant to authority vested in the Council. A quorum was present.

ATTEST:

Sharon L. Burnette
Sharon L. Burnette, Secretary
Rosebud Sioux Tribe

Ralph Moran
Ralph Moran, President
Rosebud Sioux Tribe

4-C

RESOLUTION 90-19

RESOLUTION
OF THE
SANTEE SIOUX TRIBE OF NEBRASKA

WHEREAS, the Santee Sioux Tribe of Nebraska is a Federal Corporation pursuant to Section 16 of the Act of June 18, 1934, (48 Stat. 984), (25 USC 476), as amended by the Act of June 15, 1935, (49 Stat. 378), and

WHEREAS, the Tribal Council of the Santee Sioux Tribe of Nebraska has the responsibility for the health, education and welfare of its tribal members, and

WHEREAS, the Wagner Indian Health Service Hospital serves a patient population of 7,244 people and the Santee Sioux Tribal members utilize the inpatient services of the Wagner Service Unit, and

WHEREAS, the Wagner Indian Health Service Hospital service area includes all of the Yankton Sioux Reservation of South Dakota; Santee Sioux Reservation of Nebraska; and the Eastern section of the Rosebud Sioux Reservation of South Dakota, and

WHEREAS, the Tribal Council of the Santee Sioux Tribe of Nebraska has been informed that the Indian Health Service has plans to close the inpatient services at the Wagner Service Unit in 1991, and

WHEREAS, the Tribal Council of the Santee Sioux Tribe is extremely concerned that with the closing of inpatient services, many of our tribal members who utilize the Wagner Service Unit may be without the proper health care that they need and deserve, now

THEREFORE BE IT RESOLVED, that the Santee Sioux Tribal Council opposes the Indian Health Service's Plans to close the Wagner Service In-Patient Services at Wagner, South Dakota in Fiscal Year 1991, and

BE IT FURTHER RESOLVED, that the Santee Sioux Tribal Council supports the Native American Women's Health Education Resource Center in all its efforts to keep the Indian Health Service from reducing any health care services at the Wagner Service Unit.

CERTIFICATION

This is to certify that the foregoing Resolution was considered at a Meeting of the Tribal Council of the Santee Sioux Tribe of Nebraska, duly called and held on the 11th day of January, 1990, and was adopted by a vote of 10 FOR; 0 OPPOSED; and 2 ABSENT OR NOT VOTING.

Dated this 16th day of January, 1990.

Kimberly Keeble
Kimberly Keeble, Tribal Secretary
Santee Sioux Tribal Council

Donald LaPointe
Donald LaPointe, Tribal Chairman
Santee Sioux Tribal Council

5

YANKTON SIOUX TRIBE

Box 248
Marty, So. Dak., 57361
384-3804 / 384-5687

February 6, 1990

Senator Tom Daschle
U.S. Senate
Washington, D.C. 20510
ATTN: Sara Yeager

Dear Ms. Yeager:

This letter is to inform your office that the Business and Claims Committee of the Yankton Sioux Tribe recommends and authorizes Charon Asetoyer, Director of the Native American Women's Resource Center at Lake Andes, South Dakota to testify at Senate Hearings on the Current Health Status of the Wagner Service Unit Area as contained in her study of the subject.

If you have any questions feel free to contact Charon at (605) 487-7072, or myself.

Sincerely Yours,

Stephen N. Cournoyer, Jr., Chairman
Business and Claims Committee
Yankton Sioux Tribe

Officers:
Stephen Cournoyer, Jr.
Everdale SongHawk
Darrell Drapeau
Harlan Horned Eagle

Business & Claims Committee YST

Louie Archambeau
Willard Bruguier
Raymond Cournoy
Kenneth Honomic
Edward Zephier, J

6.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Copy to: CU —
FHD —
CL. Nursing —

Memorandu

All Team Leaders should become familiar with the CHS guidlines.

Nfd 5/23/89

D.O.N. —
Lab —
X-Ray —
Pharm —
MH/SS —
M/M —

Date April 25, 1989

From AO-CHS

Subject CHS Priorities

To All SUDs, Clinical Directors and CHS Personnel

The attached CHS medical priorities have been reviewed and approved by the Chief Medical Officer, Dr. Michael Trujillo. These priorities are within the guidelines determined by the CAAD committee and are the approved priorities for the Aberdeen Area Indian Health Service.

Please insert a copy in the CHS manual for your Service Unit.

orig to Wan

Terrence W. Sloan, M.D.
Director
Aberdeen Area Indian Health Service

RECEIVED
MAY 17 1989
PHS INDIAN HOSPITAL
WAGNER, SOUTH DAKOTA

III. Preventive Services

Proven effective preventive services are appropriately divided into primary, i.e., avoidance of the occurrence of the disease, and secondary, i.e., mitigation of its consequences.

Ambulatory services of an interventional (secondary preventive) nature are included in this category if such services maintain health through preventing further long term morbidity. These services are to be distinguished, to the extent possible, from emergency care, sophisticated diagnostic procedures, treatment of acute conditions and care primarily intended for symptomatic relief and/or chronic maintenance of support.

Specific examples are: Periodic health examinations of infants, children and adults: Ambulatory interventional (secondary preventive care); Hypertension screening, diagnosis and control; Diabetes maintenance; Immunizations; Sexually transmitted diseases services; Tuberculosis control screening, prophylaxis, and treatment of active cases; Provision of routine Pap smears.

These services should be reviewed carefully by the Service Unit. Emphasis should be stressed of the availability of these services by direct IHS resources and payment denied when these resources are not utilized appropriately.

IV. Chronic Tertiary Care

This involves services that are not primarily preventive in nature, require sophisticated specialists and equipment/ procedures which are not usually available in most small community hospitals, require a large amount of support capavility, have a low cost/benefit ratio, are not immediately essential for initial hospital diagnosis or therapy in emergency situations, are eliective and have less impact on morttality than on morvidity.

Specific examples are: Allergy testing; Restorative orthopedic procedures for chronic conditions; Skilled nursing home care, periodontia, cosmetic surgery, and provisions of eyeglasses. IHS Optometry contracts should be utilized for refractions and previous years guidelines for glasses will be used, all other optometry care will be considered only when in support of direct IHS services.

V. Experimental and/or Procedures Not Proven Beneficial

Specific examples are: Chelation therapy; Multiple transplants: Refer to Memo: June 6, 1988 (Transplant Issues) and July 5, 1988 (Organ Transplants). These are attached for your reference.

NOTE: Please be advised that many of the above cases requiring CHS funding may be considered unr the deferred category. It is advisable to submit for these funds as soon as this is determined.

CHS PRIORITIES

I. Emergent and Life Threathening

The condition presents an immediate and unexpected threat to life, limb, or the senses: or presents a sufficiently unstable (immediate) potential course, uncertain but grave (immediate) probabilities, or clear deterioration of (patient's immediate) condition, such that a reasonable, average physician would not delay (immediate) intervention.

Specific examples are: Airway Obstruction; Burns; Convulsions; Eye Injuries; Hemorrhage; Lacerations; Poisoning; etc.; Emergency Care for patients with the event occuring where an accessible and timely direct care facility is not available.

This service could be returned to the Service unit (Wagner) it would raise the ADPL to 10.3

I A: Obstetrical care associated with prenatal, intrapartum, interpartum, post-partum, newborn, infant and child care that cannot be provided by the Service Unit.

Specific examples are: Pregnancy and infant care; Access to obstetricians for complicated Maternal-Perinatal conditions. Pediatric emergencies that the Service Unit cannot or is not equipped to treat.

I B: Contract Services necessary to support the provision of care in IHS direct care facilities.

Specific examples are: Contracting of such services that are required to achieve or maintain JCAHO Accreditation and are not provided through direct services. Lab/X-Ray, anesthesiologist, Specialty consultation, non-emergency surgery.

II. Acute and Chronic Primary and Secondary Treatment:

This involves basic primary care, including the treatment of prevalent illnesses that have significant impact on morbidity: primary and selected secondary hospital care and selected sophisticated ambulatory services. Provision of services within this category should have a significant impact on morbidity and mortality.

These services should be reviewed carefully by the Service Unit. Emphasis should be stressed of the availability of these services by direct IHS resources and payment denied when these resources are not utilized appropriately.

Specific examples are: Surgical expertise to manage prevalent surgical entitees; Cholelithiasis, T & A's, etc.. Management of complicated adult and pediatric illnesses; Specialty consultants should be utilized to the fullest extent possible.

ABERDEEN AREA INDIAN HEALTH SERVICE
CONTRACT HEALTH SERVICES PRIORITIES

The goal of the Aberdeen Area Indian Health Service is to raise the health of the American Indian and Alaska Native people to the highest level possible by ensuring access to quality, community-oriented health care.

It is IHS policy that this care will be provided through IHS and Tribally operated health care delivery programs utilizing direct and contract health services funds and maximally utilizing all available alternative resources.

In order to ensure that eligible users will have equitable access to needed services and to achieve optimum benefits from all available resources, the IHS and Tribally operated programs will be managed to deliver core services according to the following priority listing:

I. Emergent and Life Threatening
II. Acute and Chronic Primary and Secondary Tratment
III. Preventive
IV. Chronic Tertiary Care
V. Experimental and Procedures Not Proven Beneficial

-A

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KRISTINE A. IVERSON, MINORITY STAFF DIRECTOR

United States Senate
COMMITTEE ON LABOR AND
HUMAN RESOURCES
WASHINGTON, DC 20510-6300

March 7, 1990

Charon Asetoyer, Executive Director
Native American Women's Health Education Resource Center
P.O. Box 572
Lake Andes, South Dakota 57356-0572

Dear Ms. Asetoyer:

Thank you for your letter regarding the proposed closure of the Wagner Service Unit. I share your concern for the quality of health care for Native Americans and found your report describing the current health status of those served by the facility both informative and compelling.

A member of my staff has spoken with Ms. Yvette Joseph, a professional staff member of the Senate Select Committee on Indian Affairs. Ms. Joseph suggested that you contact Senator Daschle and ask him to formally request the testimony of your representative at the hearings on March 22. It is Ms. Joseph's understanding that a moratorium on the closure action will be in effect until after the hearings.

Thank you for bringing your concerns to my attention. I will continue to monitor the status of this action.

Sincerely,

Edward M. Kennedy

Edward M. Kennedy
Chairman

7-B

Church Women United

Washington Office, Box 16
110 Maryland Avenue NE, Washington, D.C. 20002
Telephone: (202) 544 - 8747

President
Sylvia Ross Talbot, Ed.D.

General Director
Doris Anne Younger, D.MIN.

DT: January 12, 1990
TO: Charon Asetoyer
FR: Nancy Chupp
RE: "Current Health Status..." report sent to Claire Randall

Thank you for sending this report to us at Church Women United. Claire forwarded it to me in the Washington legislation office since we are better equipped to work with Congress.

After reading the report I am duly aware of how important the Wagner Service Unit is to the Reservations in South Dakota.

When Congress returns at the end of January, we will send a letter to members on the Committee on Indian Affairs and possibly do some grassroots work to contact others Senators.

Thanks again for drawing our attention to this issue and let us know if their are other actions that can be taken.

Nancy Chupp
Legislative Research Assistant

Church Women United is a national movement of Protestant, Roman Catholic, Orthodox and other Christian women.

7-C

National Organization for Women, Inc.
1000 16th Street, NW, Suite 700, Washington, DC 20036-5705 (202) 331-0066 FAX (202) 785-8576

February 27, 1990

Senator Daniel K. Inouye
U.S. Senate Committe on Indian Affairs
722 Hart Senante Building
Washington, D.C. 20510

Dear Senator Inouye:

It has come to the attention of the National Organization for Women (NOW) that a proposal has been submitted by the Indian Health Services to close the Yuma, Owyhee, Fort Belknap and Wagner Service Units due to financial reasons. We understand that these closures, and in particular the Wagner Service Unit, have been opposed by the entire Native American communities on the reservations in which they operate.

The Native American Women's Health Education Resource Center, which operates out of the Yankton, Santee and Rosebud Sioux Reservations, has been the source of our information. We understand from them that the Native American Community Board, the Yankton Sioux Tribal Council and the Yankton Sioux Health Board all are in opposition to the closures of the inpatient care services and are seeking the continuation of direct inpatient services. We join them and the Native American Women's Health Education Resource Center in this request.

As we understand it the Units in question provide vital care to the Native American community on these reservations. Surely this country, while bailing out the Savings and Loans, can find the money to keep the Yuma, Owyhee, Fort Belknap and Wagner Service Units open.

If you have any materials regarding this matter we would appreciate receiving them. In the meantime, please convey NOW's opposition to the closures of the Service Units to the Senate Committee on Indian Affairs when deciding the fate of these vital services.

Sincerely,

Molly Yard
President

cc: Charon Asetoyer, Executive Director
Native American Women's Health Education Resource Center

United States Senate
WASHINGTON, D.C. 20510

December 20, 1989

Ms. Charon Asetoyer
Native American Women's Health
  Education Resource Center
Post Office Box 572
Lake Andes, South Dakota 57356

Dear Ms. Asetoyer:

It has come to my attention that the Indian Health Service has plans to close the Wagner Service Unit inpatient services at Wagner, South Dakota. I am writing to express my concern over the possible ramifications of this action.

As you know, the area served by the Wagner Service Unit suffers from severe health problems characteristic of an economically devastated area. For example, eighty-five percent of the population is unemployed and twenty-three percent of the families are headed by single women with incomes far below the poverty level. Seventy percent of the population over the age of forty is diabetic, and tuberculosis is 22 times more common than the national average. The infant mortality rate in the Wagner Service Unit is an appalling 28.8. It is my understanding that closing the inpatient services at Wagner will only exacerbate these already terrible conditions. At a time when we should be paying more attention to the problems faced by our Native American populations rather than less, I find this disturbing.

I would appreciate your prompt review of this situation. I would also appreciate your providing me with any information that you feel might be helpful to my understanding of this problem. Thank you very much for your cooperation.

Sincerely,

Bill Bradley
United States Senator

BB/mtz

MAR 21 '90 15:42 202-628-3348 NYBB P.1/1

1-E

NATIONAL WOMEN'S HEALTH NETWORK

Senator Daniel K. Inouye
U. S. Senate Committee on Indian Affairs
722 Hart Senate Building
Washington, D.C. 20510

Rec'd 3-21-90

Dear Senator Inouye:

The proposed closing of the inpatient services of the Indian Health Service Units at Yuma, Owyhee, Fort Belknap, and Wagner is commanding national attention, and as the National Women's Health Network, we are paying special attention as we are concerned about issues of women's health.

The Native American Women's Health Education Resource Center of Lake Andes, South Dakota, is within the Wagner Service Unit's area, and has been our source of information. South Dakota has one of the highest mortality rates in the United States (27.8) and the Wagner Service Unit's mortality rate is 28.8. This unit, as well as the Yuma, Owyhee, Ft. Belknap Units, provide vital care to the Native American women and children and we are in opposition of the inpatient care closure.

We would like to have it on record that we, The National Women's Health Network, are in opposition to the closures of the service units to the Senate Committee on Indian Affairs.

Sincerely,

The only national public-interest organization devoted solely to women and health
1325 G Street, N.W. • Washington, D.C. • 20005 • (202) 347-1140

RCAR
EDUCATIONAL FUND
RELIGIOUS COALITION FOR ABORTION RIGHTS
100 Maryland Avenue, N.E. • Suite 307 • Washington, DC 20002 • (202) 543-7032

March 21, 1990

Honorable Daniel Inouye, Chairman
Senate Select Committee
On Indian Affairs
SH-838 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Inouye:

The Religious Coalition for Abortion Rights urges the Senate Select Committee on Indian Affairs to allow for the continuation and expansion of in-patient health services at Wagner Indian Health Service Unit in South Dakota.

The Religious Coalition for Abortion Rights is a national organization of 34 Protestant, Jewish and other faith groups who believe that abortion should be kept safe, legal and accessible to all women. While each of our member faith groups views abortion from its own unique perspective, we believe that no one religious viewpoint on the beginning of life should be imposed on all Americans by secular law. Thus, our belief in reproductive freedom is closely tied to our belief in religious freedom.

We also believe that women should be supported in their decision to bring their pregnancy to term. For poor women -a disproportionate number of whom are women of color - being supported in their decision to bring a pregnancy to term is not a reality. This is one of the reasons that RCAR established its Women of Color Partnership Program.

It is through the work of RCAR's Women of Color Partnership Program that we know all to well the realities of access to health care for Native Americans, especially pregnant Native American women. Lack of access to health care has had a significant impact upon the extremely high infant mortality rates faced by Native Americans in South Dakota. While 90 percent of non-white infants are Native American, their infant mortality rate is an astronomical 27.5 per 1,000 live births. Through our close association with the Native American Women's Health Education Resource Center of the Native American Community Board, we are working to assure access to adequate health services and hope to see these rates decreased.

Over the last several years, Wagner Indian Health Service Unit has seen little or no improvements in service delivery and in the physical plant. Closing down Wagner will severely limit health services to a population which is already suffering from inadequate health care.

Based upon our work in South Dakota, it is our opinion that IHS has been systematically reducing in-patient services at Wagner over the last four to five years. Recently, Wagner ceased labor and delivery services. It is interesting to note that IHS has stated that their latest daily census for patients is 7.5, with births totalling 8 per year.

Further, IHS failed to mention that the 8 reported Wagner births were emergency deliveries where the patient was unable to travel the required sixty miles to the IHS contracted facility in Yankton. Based on data collected in the community, it has been projected that if Wagner were still providing labor and delivery services the number of births would have been approximately 90 per year.

The Religious Coalition for Abortion Rights, again, urges you to leave the Wagner facility open and to allow for the expansion of health services and improvements in health delivery. We would also hope that the Wagner facility would be identified for receipt of funds to expand in-patient and rehabilitation services and for improvements in the physical plant.

Sincerely yours,

Patricia A. Tyson
Executive Director

Enclosures

8.

Native American
Women's Health Education Resource Center

A PROJECT OF THE NATIVE AMERICAN COMMUNITY BOARD

Current Health Status of the Wagner Service Unit Area
(Yankton, Santee and Rosebud Sioux Reservations)
and the
Effects of Indian Health Services Proposed Inpatient Service Closure

Report by:

Raelene Walker
Stanford University
School of Arts and Sciences
Department of Biological Sciences
Program in Feminist Studies
Stanford, California

Summer of 1989

Charon Asetoyer, B.A. M.A. M.I.A.
Executive Director
Native American Women's Health
Education Resource Center
Lake Andes, South Dakota

P.O. BOX 572 • LAKE ANDES, SOUTH DAKOTA 57356-0572 • 605-487-7072

Introduction

In 1985 a group of Native Americans living on (or near) the Yankton Sioux Reservation in South Dakota formed the Native American Community Board to address pertinent issues of Health, Education, Land and Water Rights, and Economic Development of Native American people. In 1986 the Native American Community Board incorporated under the laws of South Dakota as a non-profit tax exempt 501(c) 3 organization. The first NACB project developed was "Women and Children in Alcohol", a Fetal Alcohol Syndrome program. It was through the "Women and Children in Alcohol" program that we were able to define the direction of our health work.

In February of 1988 the NACB opened the first Native American Women's Health Education Resource Center located on a reservation in the U.S., based in Lake Andes, South Dakota, on the Yankton Sioux Reservation. The Native American Women's Health Education Resource Center provides several different kinds of services and resources to women, children and the community. Health education, prevention, wholeness, child development, domestic abuse intervention services, and adult learning are some of the key services provided at the Resource Center. The Resource Center also does advocacy work for children and women and has become a center for promoting and facilitating social changes around issues that are pertinent to the health and well-being of the Native American community as a whole.

Over the last year and a half the Resource Center has been directly involved in bringing national attention to the devastating problem AIDS is having on the Native American community. We have also been a major element in organizing the community to defeat a joint venture between the tribal government and a private company from bringing in a "trash recycling project" which had the potential of bringing in over 100 tons a week of toxic waste into our reservation community. That project posed major environmental threats to our ground water and the Missouri River as well as potential health problems to the people.

In early spring of 1989 I became aware that the Wagner, South Dakota Indian Health Services Hospital inpatient services were going to be closed down in 1991. There had been some talk in the community about the Indian Health Service Hospital expanding and a new outpatient facility opening in 1991, although no one had mentioned anything about our reservation loosing its inpatient services when the new outpatient clinic opened. After asking several community people, Tribal Health Board members and Yankton Sioux Tribe Business and Claims Committee members about the closing of inpatient services, no one was really well informed or aware the services would be closed. People were only aware of the new outpatient clinic to be constructed and opened.

Therefore it became clear the need for the community to be informed of this major loss and to inform the powers that be, the impact of such a loss of services would have on the community.
--Charon Asetoyer

Summary

Indian Health Services is currently facing financial shortfalls, particularly in the area of Contract Health Services. FY 1989 shows an overall deficit of $46 million, $24.2 of which comes from contract care.

IHS is planning to close the inpatient services at Wagner Service Unit in Wagner, South Dakota on the Yankton Sioux Reservation. Upon closure, the proposal is to contract out the eliminated services. However, for financial and practical reasons, this plan would result in inaccessibility of comparable services to those that are currently offered. The proposal would effectively limit available inpatient services to only life-threatening emergencies and childbirth.

The current status of health in the service population is extremely poor. The median age of Native Americans is much lower than the general population, 22.6 compared to 30.0, and the mortality rate is 2.7 times higher. Seventy percent of the population over the age of forty is diabetic and secondary complications of the disease are prevalent. The general diet is very unhealthy which contributes to diabetes and other conditions such as heart disease, cancers, and overall health problems. Tuberculosis is 22 times more common than in the national population and pneumonia and influenza are also serious health problems. The infant mortality rate is highest among Native Americans of any racial group in the country at 27.5 deaths per 1000 births in South Dakota and is even higher in the Wagner Service Unit area, 28.8 deaths per 1000 births. The national average is 10.4 deaths per 1000 births. Pregnant women receive regular prenatal care only 37% of the time and the birth rate is 2.4 times higher than the U.S. rate. Alcoholism is a problem of epidemic proportions and the rates of associated problems of fetal alcohol syndrome, liver disease, other diseases, accidents, and murders are all well above national averages. Domestic abuse and environmental hazards contribute to the drastic health problems as well.

The Wagner Service Unit serves an area of 3714 square miles which is one-half the area of New Jersey and nearly twice the area of Delaware. The patient population is 7244 with only three physicians, nearly five times the national average physician/patient ratio. The Service Unit does not offer any community prevention, education, or awareness programs.

Economically, the service population is devastated. The unemployment rate is 85% and the average annual income for a six person household is only $6040. Twenty-three percent of the families are headed by single women whose average annual income is $4623, the lowest of any group in the country. IHS is the only health care provider for 91% of the population as only 0.5% of the population has private health insurance.

To close inpatient services would have catastrophic consequences for the health needs of this population and contract care will not be able to adequately provide for these tremendous needs. Other options such as a Health Maintenance Organization are not feasible, either. Under the leadership of the Yankton Sioux Tribal Council and the Yankton Sioux Health Board, the community has opposed the inpatient closure and in a written resolution has demanded that IHS continue direct inpatient services. Nonetheless, IHS is currently moving forward with the closure plans.

Historical Perspective and Background

Indian Health Services (IHS) developed out of the need to provide medical services to American Indians. Health services began in the early 1800s though the first actual treaty providing for health services was not introduced until 1832. Initially the need was to control contagious diseases such as smallpox introduced by the white population through military posts. As Native Americans were moved onto reservations and forced into dependency on the federal government, health conditions continued to deteriorate and in response the health service programs continued to expand. In 1955 the program transferred from the Department of War to the Department of the Interior and took on its current structure and goals [1]. Officially, IHS has the following objectives:

> "to elevate the health of American Indian and Alaska Native people to the highest possible level. The mission is to ensure equity, availability and accessibility of a comprehensive high quality health care delivery system providing maximum involvement of American Indians and Alaska Natives in defining their health needs, setting health priorities for their local areas, and managing and controlling their health programs. The IHS also acts as the principal Federal health advocate for Indian people." [2]

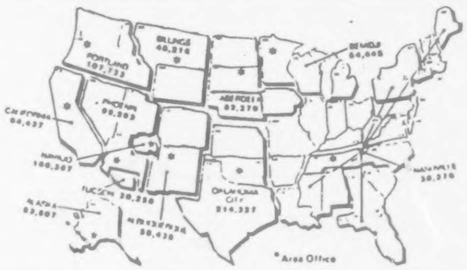
Indian Health Services recognizes that "the problems that these citizens encounter in preserving health and obtaining needed health care exceed those of most other Americans" [3]. IHS therefore seeks to provide medical services in hospitals, health centers, clinics, and schools as well as health outreach and educational programs. Overall, the IHS program currently provides local health care services to over

1 million Native Americans across the United States [4]. These people are spread out over 278 federal reservations and 209 Alaskan Native villages [5].

At the national level, the IHS agency falls under the same heading as the Public Health Service (PHS), within the Department of Health and Human Services. Both these agencies have central offices located in the greater Washington D.C. area. Below the IHS in organizational structure are twelve Area Offices which are located around the country near the larger Native American populations [6]. These include Aberdeen, SD; Alaska; Albuquerque, NM; Bemidji, MN; Billings, MT; California; Nashville, TN; Navajo (Utah, Arizona, New Mexico, Colorado); Oklahoma; Phoenix, AZ; Portland, OR; and Tucson, AZ. These Area Offices are located both in urban cities with large Native American communities (i.e. Albuquerque, Phoenix, Portland, Tucson) and in rural areas on or associated with designated reservations (i.e. Aberdeen, Alaska, Navajo, Oklahoma) [7]. The attached map illustrates these twelve locations and indicates the relative population of each of the Area Offices (Figure 1).

Indian Health Service Population by Area

Total Service Population, FY'89 Estimate: 1,073,572



The Area Offices are then further broken down into Service Units. These are the actual hospitals, the places where people go for services and medical treatment [8]. Service Units are spread out within the regions covered by the Area Offices. Some are responsible for a single large community as in a city, while most others provide care for a much larger area and can encompass several different reservations and communities. For example, under the Aberdeen Area Office are thirteen Service Units that provide services for fifteen different reservations [9].

IHS Funding and Contract Health Services

The funding for IHS is appropriated annually by Congress with the actual dollar amounts requested and allocated by the Public Health Service and the Department of Health and Human Services in Washington D.C. These agencies determine allocations of funding on a historical basis to try to provide a "program continuity budget approach" with line-by-line item increases [10]. This means they attempt to provide the same level of funding and service capacity from year to year. Increases are included only for specific changes such as additional programs and needs. Individual increases are directed to the specific Area Offices and/or Service Units that require the extra funds and are not distributed generally [11].

The number of patients served is not the only factor in determining the amount of funding. Per capita information was used nearly exclusively in the past, but current funding distribution is determined with a system called Resource Allocation Methodology (RAM). This process attempts to take into consideration additional factors such as the location of the Area Office and the level of need for care as indicated by morbidity and mortality statistics. From there, a similar process is used, called Service Unit Resource Allocation Methodology (SURAM) for the distribution of the money from the Area Offices to the Service Units [12].

Currently, IHS is experiencing financial difficulties. They estimate that $24.6 million is needed in order to balance the fiscal year that starts around July 15, 1989. This is the amount of money needed to "restore drug inventories to a more suitable and responsible level" and to provide needed contract care [13]. Contract care refers to a type of indirect care offered by IHS. Since many of Service Units are in areas that do not maintain complete hospitals, certain unavailable services are "contracted out". This means that patients are referred to outside, non-IHS hospitals that do provide the needed services. This is done on a prioritized basis of need and is paid for out of a designated segment of the budget [14]. Payment is made from IHS to the contract facility on the basis of the process called Diagnostic Related Billing (DRG). This amounts to coverage of 82% of the bill and is the same system that Medicare uses. This case-by-case method of payment follows the previous use of flat rates for each different service contracted out [15].

The division within IHS called Contract Health Services (CHS) is responsible for these indirect services and has its own budget within the total allocations. This amounts to approximately 26% of the IHS clinical services budget [16]. CHS funding is determined in the same way as the total funding levels and the financial problems of this department are responsible for many of the general shortfalls that IHS has been experiencing. Overall, IHS expects a yearly shortfall in the 1989 fiscal year of around $45 million. The breakdown for this shortage is contract care ($24.2 million) as well as the fiscal year 1989 Pay Act ($13.4 million), higher than expected pay costs to personnel ($7.4 million) and an overall increase in costs 3 to 4 percent higher than the anticipated amount [17]. The last part has to do with the inflationary allowance based on the Consumer Price Index that is included in the budget to balance the rising costs of medical services. From the 1988 budget, the increase was 5.8 % and sought to "minimally meet the rising cost of medical care purchased from the private sector". However, for inpatient care the costs from the private sector rose approximately 10% and for outpatient care, 13% [18]. Therefore, the 5.8% allowance was insufficient and provided for less buying power than needed in order to maintain the same level and number of services.

Another reason for the shortage of overall funds has been the lack of focus on the number of patients being served. Just between 1988 and 1989 the number of people served by IHS increased 3.5% and no arrangements were made for this increased patient load [19]. Much of this problem was foreseen by the Office of Technology Assessment. In their 1986 report on Indian Health Care, they stated "Given expected rates of increase in general health care costs relative to likely IHS budget increases, even the most efficient management techniques will not be able to overcome the problems of inadequate funding and a growing service population in the IHS contract program" [20].

In an effort to avoid this shortfall, Congress appropriated $10 million in 1988 to an additional CHS fund, the Catastrophic Health Emergency Fund (CHEF). This is a revolving fund over all of IHS to cover individual high cost cases, intended to "shield IHS and tribally contracted health care operations from financial disruption caused by high cost illnesses or events" [21]. Otherwise, these individual high cost cases could deplete a large percentage of the contract funds from specific Service Units, leaving no money for other necessary cases. With CHEF, needed and prioritized high cost services could be offered and funded from this reserve fund rather than the local budget. In

1988 CHEF expenditures exceeded its allotment by $5.2 million. Every Area Office contributed to this shortfall. In 1989 all Area Offices also expect to fall short in their CHS needs for a total negative balance of $21 million [22]. This demonstrates that the financial problems are not due to individual programs, but rather are at the federal level with funding simply being inadequate even to meet the stated IHS goals.

The prioritizing of services determines what needs will be referred over other needs in an attempt to accommodate the most pressing ones. With the current shortage of money, all areas are only able to refer Priority 1 cases, and not even all of these. This classification "allows for the provision of contracted services to those individuals who need emergent and acutely urgent care" [23]. These are life threatening emergencies and childbirth. With the deficit and with inadequate funding increases, "fewer Priority 1 services will be funded and will probably result in the IHS' inability to pay for over 2000 needed hospital admissions and over 3000 ambulatory visits" [24]. The determination of Priority 1 cases is the following:

1. an immediate threat to life, limb, or the senses
2. a sufficiently unstable (immediate) potential course
3. uncertain but grave (immediate) probabilities
4. a clear deterioration of a patient's immediate condition, such that a reasonable average physician would not delay immediate intervention [25].

Many of these cases are not receiving treatment. Indeed, the Omaha IHS hospital states in its orientation packet, "the CHS budget is never adequate to cover all the medical needs which we are able to define each year" [26]. More critically, once funds run out, for the remainder of the fiscal year no services are referred at all through CHS [27]. Patients and outside hospitals can make their own arrangements but as Senator Inouye states in his letter to the Secretary of Health and Human Services, "This simply means that Indian people who are predominantly unemployed and uninsured will go without life-saving medical care" [28].

Obviously, even when the Priority 1 cases cannot all be contracted out, all lesser priorities are not met. These services include everything except emergencies and childbirth. Emergency, as defined by IHS is "any medical condition for which immediate medical attention is necessary to prevent the death or serious impairment of the health of an individual" [29]. However, these non-life threatening conditions still require medical attention and these needs should be met as part of the official IHS goal to "provide and/or assure the availability of high quality comprehensive, accessible health services" and for reasons of basic human rights [30].

Proposal for Closures of IHS Inpatient Care

Indian Health Services is looking into closing inpatient facilities at seven different Service Units. In the immediate future, the proposal deals with four in particular. These are in Yuma, AZ; Owyhee, NV; Fort Belknap, MT; and Wagner, SD. In proposing these changes, IHS must first complete a Program Justification Document for each proposed change. Then, prior to any actual closure IHS must also notify Congress in order to obtain approval of this change [31].

The proposals are moving ahead in both Yuma, AZ and Fort Belknap, MT. Both these cases involve building new clinic facilities and closing the present inpatient hospital services. The intention is then to contract out those eliminated inpatient services to outside hospitals. Currently, the construction of the new outpatient clinics is progressing. The Service Units in Nevada and South Dakota have similar proposals, but have additional requirements to fulfill before proceeding. As yet, Congress has not received official notification of any of these proposed closures [32].

The Wagner proposal is also to build a new outpatient clinic and then to close down the present inpatient facilities and to contract out those services. The eliminated services would be contracted out to the Wagner Community Hospital also in Wagner, SD. The specific services that would be affected include all inpatient care. The rest of the Service Unit would continue to operate as it does now. Remaining services would include twelve hours per week of regular clinic and a total of six hours per week for prenatal, postnatal, and gynecology, diabetic, and well child clinic. These latter clinics all have specific hours when the various services are available. Also, once a month are clinics for ear, nose, and throat and orthopedics for 2 to 2 1/2 hours [33]. The services that are currently contracted out would still be contracted out to the same hospital that they are now, Sacred Heart in Yankton, SD [34].

The new services that would be contracted out would have to be funded by Contract Health Services. The policy would be to follow the Priority system for all these contract services [35]. However, as already discussed, funding for CHS is not adequate for all the cases that need service. In fact, currently it is not even adequate to fund all the necessary Priority 1 cases. The expected shortfall for the fiscal year 1989 in the Aberdeen Area alone is $1,140,000 and the catastrophic shortfall in fiscal year 1988 for the Aberdeen Area was $98,000 [36]. Currently, Wagner has only $280 per patient for contract care [37]. According to Vern Donnell, Wagner Service Unit Director, this amount is unlikely to increase significantly when additional services need to be contracted out and routine increases in funding would be insufficient to fully provide for the needed number of cases [38].

Funding is not determined per capita. Because allowances are made for inflation the dollar amount of funding per person does increase among the same population size. However, when the service population also increases this money can provide fewer services for each patient. Over time this is effectively less dollar value, less money per person [39]. Combined with that shortage is the greater need for contract services that the inpatient closure would bring about. As a result, funding would simply not be available for contracting out all the inpatient services that are currently offered at the Wagner Service Unit. Due to these funding problems, services would then be restricted or eliminated as people would no longer have access to them.

In the event that contract funds do run out, no more cases can be contracted out. It is not possible to operate on credit or to use funds from the next fiscal year [40]. This is expected to occur and when it does, the Aberdeen Area plans to issue denials [41]. They will still refer patients to the outside hospital and will advise both parties regarding the need for the service but it is between the patient and the service facility. IHS is no longer involved. Wagner Service Unit Director Vern Donnell states, " allocation is far too little. [There is] nothing you can do about patients who get sick or are injured when money runs out" [42]. Theoretically, if the case has been referred by IHS and is provided by the service facility, back payment could be made later by IHS. However, this would only occur in the event of a surplus over the entire IHS program. If that occurred, IHS would go back and pay for some of these deferred cases [43]. However, with a projected FY 1989 deficit of $45 million and no major funding changes planned, this is extremely unlikely and can be effectively rejected as a possibility.

The U.S. government uses the Snyder Act of 1921 as the basis for health services to Native Americans. That document has been interpreted by the courts as providing voluntary benefits [44]. However, in treaties signed by the United States and the Sioux nation prior to the Snyder Act which these tribes still recognize and uphold, health services are obligatory [45]. From this standpoint, failure to provide services when contract funds run out is a direct violation. It also opposes the IHS objectives.

For Wagner, the Program Justification Document states that the Service Unit must meet a specific set of criteria before the proposal can go into effect. These specifications include the following four items: accreditation of the contracting hospital by the Joint Commission on Accreditation of Hospital Organizations (JCAHO), personnel staff privileges from the contracting hospital to the IHS physicians, patient care surveillance, and inclusion of American Indians on the contracting hospital Board of Directors [46]. Two of these criteria have not been met which has delayed the implementation of the program. These are the accreditation of the contract facility by the Joint Commission on Accreditation of Hospital Organizations (JCAHO) and the inclusion of tribe members on the hospital governing board of the contract hospital. Wagner Community Hospital is currently licensed by the state of South Dakota and to be accredited by JCAHO would be costly. Concerning the hospital governing board, the criteria is to have two Indian members join the board [47]. Wagner Community Hospital has agreed to allow one Native American with the stipulation that this person be a non-voting member. Voting members must be elected by the hospital association of community members over which the hospital has no jurisdiction [48].

The proposal schedule for Wagner was originally intended to take effect in 1991, but has now been set back about one year. Planning of the new outpatient clinic is finished including design and concept drawings. Current plans are to complete the design by

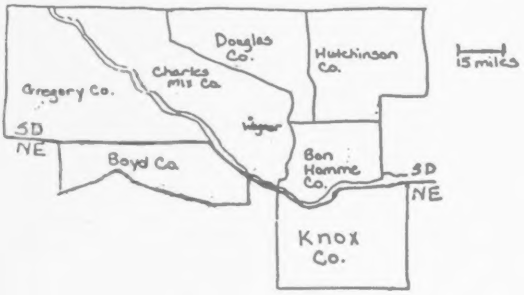
March 1990 and to begin construction in June 1990. Funding has been allocated and appropriated in the amount of $4.2 million in FY 1989. No money was designated in FY1990, however [49]. Despite the problems and delays IHS intends to proceed with the inpatient closure as soon as the specified criteria are met [50].

The Yankton Sioux Tribal Council and the Yankton Sioux Tribal Health Board are concerned about the elimination of inpatient services at the Wagner Service Unit. About two years ago they met with IHS representatives demanding the continuance of direct inpatient services [51]. However, this demand was rejected by the national headquarters of IHS shortly thereafter and the closure proposal is presently going forward in spite of the concerns of the Tribal Council [52]. IHS never directly notified Tribal Council of the rejection of their demands or the community at large about the impending closure. Most people are unaware of the plan to eliminate inpatient services at the Service Unit and to then contract out. In fact, even members of the Health Board do not have a clear understanding of the present proposal. However, when informed and made aware of the planned inpatient closure, people are concerned for their health. Tribal Council and Health Board members plan to meet again with IHS representatives to discuss their demands and they intend to work toward keeping direct inpatient services [53].

Wagner IHS Service Unit

The Service Unit in Wagner serves the Yankton and the Santee reservations as well as part of the Rosebud reservation. People are eligible for services from IHS by being Indian and having residence established within the designated area. They can either be actual members of the Yankton Sioux, Santee Sioux, or Rosebud Sioux tribes or have "close social and economic ties with one of these tribes" [52]. As of October 1989, people remain eligible for IHS services for three months after termination of residency even if they are a tribe members. Prior to that date, eligibility extended for six months after termination of declared residency [53]. Ninety-one percent of the residentially eligible people use IHS as their source of health care [54]. Rosebud is included because part of the Rosebud reservation is closer in distance to Wagner than to its own Service Unit which is located in Rosebud, SD, much farther to the west. All three of these individual tribes are members of the Sioux nation. Figure 2 outlines these areas and illustrates the large area and far distances that the Wagner Service Unit covers.

Wagner Service Unit Area



Specifically, it provides care for an area 3713 square miles in size [57]. This is roughly equivalent in size to one-half the state of New Jersey or two times the state of Delaware. People in the service area have to drive as many as 95 miles in order to obtain medical care [58]. With the available roads from the various communities to the Service Unit, in good weather the travel time to cover these distances is about two hours. Obviously, this time is greatly increased with poor road conditions due to storms, ice, wind, or snow.

The Service Unit does not have the means to offer all of its services at the Wagner facility. The local emergency room is maintained as a Level III, non-critical care facility, so serious emergencies are contracted out as well as childbirth, surgery, ophthalmology, and other more specialized or complicated medical services. Most of these cases go to Yankton, SD which is 56 miles from Wagner [59]. When cases are more serious or require more advanced equipment or specialists than Yankton can provide, patients are contracted out to one of four other hospitals. These are McKennan Hospital and Sioux Valley Hospital, both in Sioux Falls, SD, the army hospital in Denver, CO, and the University Hospital in Minneapolis, MN [60].

The idea behind this proposal began around five years ago at the Area Office level [61]. In fact, the Program Justification Document from which the officials are still working was completed in May 1986 and approved on September 15, 1986 with subsequent approval by the Public Health Service on July 20, 1987 [62]. Therefore, it is already three years out-of-date. Indeed, according to Donnell, patient levels have increased and continue to do so. Patient statistics reflect this. The Program Justification Document sites an ADPL of 6.3 for 1985 [63]. By 1988 the ADPL had risen to 8.9 [64]. This represents an increase of 41%.

The rationale behind the idea to close inpatient services is to avoid duplication of services and to increase cost effectiveness [65]. However, in the given circumstances, closing inpatient services at the Wagner IHS would not solve duplication of services because these services would be available on a much more limited basis. More accurately, this would be elimination of services. Regarding cost effectiveness, money would be saved if services were not offered or offered less. The services themselves would not be any less expensive, however. In fact, purchasing them from the private sector could easily cost more. Contracting out adds on transportation costs, too. In addition, the new clinic facility is budgeted for $10,332,000 which must be taken into consideration [66].

The justification of eliminating the inpatient facilities at Wagner is based partly on the IHS evaluation of present use of the facilities. The Aberdeen Area Office reports an Average Daily Patient Load (ADPL) of 6.3 patients per day at the Wagner Service Unit [67]. They estimate that operating with less than fifteen patients per day is 50% to 75% more expensive than purchasing the same services from the private sector [68]. Estimations were not included on the amount that would be saved if the hospital merely reduced the number of beds. Also, this does not take into account the administrative costs of contracting out or of the construction costs of over $10 million to build the new clinic. In addition, the following statistics from the Aberdeen Area Office for the years 1986 through

1988 of the number of patient days of inpatient care shows slightly higher and increasing figures for ADPL, especially if current contracted patients are included [69]:

Wagner Service Unit-Inpatients Served, 1986-1988

	1986	1987	1988
general medicine	1028	1838	1634
general surgery	12	0	0
obstetrics	159	78	57
pediatrics	438	296	450
alcoholism	0	30	0
newborn	64	26	15
general contract	669	805	510
contract newborn	20	68	72
contract mental disorder & alcohol treatment	0	0	505

Including all the inpatients served, the ADPL was 6.5 in 1986, 8.6 in 1987, and 8.9 in 1988. This is an increase over the three year period of 36%. These information only deals with the financial aspects of the closure. The circumstances of the community as well as physical and emotional health factors must also be considered.

In addressing the proposal to eliminate inpatient care, the economic situation and resources of the affected community are significant. The people who receive services from the Wagner Service Unit are virtually destitute, economically. For all Native Americans, the unemployment rate as determined by the 1980 census is around 15% [70]. In this area the unemployment rate is officially reported as 85% [71]. The average annual family income in the United States for all races is approximately $23,000 compared to $15,000 for average Native American families [72]. On the Yankton reservation, the average family income for a household of six people is approximately $6040 [73]. In addition, 23% of Native American households, nationally, are headed by women [74]. In the Wagner area this percentage is even higher and the median income for this group is the lowest of any in the country at a mere $4623 per year [75]. Obviously, then, these people have no means to purchase private medical insurance or private medical services. Nor can they supplement the services of IHS with their own income.

Health Issues for Native Americans in the Wagner Service Unit Area

The Native American communities that are affected by the IHS proposal have several specific health problems and issues that need to be addressed individually. The general status of health is directly indicated by median age. For Native Americans the median age is only 22.6 compared to 30.0 for the U.S. all races groups [76]. This illustrates the fact that Native Americans have lower life expectancies than the general population and higher mortality rates. This is more severe in the area including Wagner. Among the twelve Area Offices, Aberdeen has the highest age-adjusted death rate, 1261.3 per 100,000, a factor 2.3 times the rate for the general population of the U.S. [77]. For the Wagner Service Unit it is even higher, 1470.6 deaths per 100,000 [78]. This is 2.7 times the U.S. rate. Of course, these statistics do not really address the current health conditions of the people. These need to be addressed individually.

Diabetes is a major health problem in the Native American population and especially in the Wagner area. The Native American Community Board estimates state that 70% of the adult population over the age of forty on the Yankton reservation is diabetic [79]. These people all require regular medical check-ups and treatment. In fact, the Wagner Service Unit estimates that 40% of all patient visits pertain to diabetes either directly or indirectly and approximately 90% of the patients are on insulin treatment which requires further services from the Service Unit [80]. Also, many of these cases are not caught quickly or treated regularly which results in a very high rate of the secondary characteristics of this disease. These include heart conditions, strokes, amputations, dialysis for kidney dysfunction, and vision problems leading to blindness [81]. These severe medical conditions necessitate active medical care and readily available services. Just to regulate the blood sugar of someone without any secondary complications can require many hours of inpatient care [82]. Thus, the services of the Service Unit are used extensively for diabetes itself and for the additional effects of this disease.

In general, much of the problem with diabetes is due to the diet on which most of the members of these communities subsist. The diet mainly consists of rations from the US Department of Agriculture Commodity Program which are fruits and vegetables packed in heavy syrups and sugars, processed white flour, shortening and red meat preserved in heavy salts. Therefore, people eat little or no fresh produce, whole grains, or complex carbohydrates. The foods people mostly do without are the ones that have been recommended by the American Heart Foundation and the American Cancer Society as useful in preventing heart disease, cancers, and hypertension and by the American Diabetes Association for controlling diabetes. Since this is what is lacking in the diets, though, the Indian communities are already at higher risk for some of these diseases. The problems associated with diabetes are greatly compounded as well. Thus, these people have health problems relating to diet alone that also combine and interact with the other health problems to make both problems more severe.

Tuberculosis continues to be a health threat to the Native American population even though it is a treatable disease. The age-adjusted mortality rate for tuberculosis in reservation states is 6.6 times greater than for the U.S. all races population [83] and Native Americans have the disease 22 times more often than the general public [84]. The fact that this is the current situation underlines the deplorable state of health for many Native Americans and the need for health education and prevention programs. It also illustrates the ineffectiveness of the current IHS education and prevention programs.

Infants are another major health issue group in the Native American community. According to the Children's Defense Fund, the South Dakota non-white population which is 90% Native American has the highest rate of infant mortality in the country, 27.5 deaths per 1000 births [85]. In the Wagner area it is even higher, 28.8 per 1000 live births [86]. This compares to the national average of 10.4 deaths per 1000 births and a rate of 13.3 in the South Dakota general population. To offer perspective, the Native American infant mortality rate is 35% higher than it was the previous year and is also higher than many third world countries, more than 50% higher than Bulgaria, Cuba, and Costa Rica. Comparatively, the overall state infant mortality rate is poor, too, tied for the highest rate of all states in the nation [87]. These statistics include birth through the first year of life.

Much of the health problems result from the lack of prenatal care that the pregnant women receive in addition to poor diet and the young age of mothers. The teen pregnancy rate is higher here than the U.S. rate [88]. In South Dakota only 37% of the pregnant Native American women receive regular prenatal care compared to the nearly double, but still low 64% of white women receiving regular prenatal care [89]. The average age of a first time mother among the Native American population is lower than the average age in the white population. Low birth weight is another common problem in this population and is known to be definitely associated with poorer health for the baby. In the Wagner area, 13% of the births occur with less than 37 weeks of gestation. In fact, 25% of the infant mortality is due to "disorders relating to short gestation and low birth weight" [90]. The leading cause of hospitalization for the Wagner Service Unit, direct or contract, is complications of pregnancy, childbirth and puerperium. This is followed by injuries and poisonings, respiratory system diseases, and digestive system diseases [91].

The birth rate in the Wagner area is 2.4 times higher than the U.S. all races rate and young Indian children continue to suffer in higher levels from certain illnesses than the non-Indian population. They get sick more often and more severely. In the Aberdeen area, the mortality rate from pneumonia and influenza which often affects children is almost 4 times the U.S. rate [92].

Alcoholism and alcohol consumption is high in the Native American population and this tends to continue throughout pregnancy. Direct evidence for this is that the Native American population has a 1% frequency of Fetal Alcohol Syndrome (FAS) and a 2% frequency of the lesser degree, Fetal Alcohol Effected (FAE). This is contrasted by the much lower rates in the general population of the nation, 0.001% to 0.003% for FAS and for 0.0013% FAE [93]. According to the Native American Community Board, "it is estimated that in 2 1/2 to 3 generations that every Native American household will have at least one spouse who is a descendant of FAS/FAE parents" [94]. As a result, the need for health care and medical services for infants is greater than the needs in the national population. Again, the need is especially great for educational and preventative health services.

Alcoholism and alcohol related diseases are also very prevalent and require medical services. These conditions include gastrointestinal diseases, liver damage, cardiovascular disease, malnutrition, brain damage, cancers, drug interaction, accidents, murders, suicides and all require extreme intervention and care, including treatment and counseling [95]. In fact, death from alcoholism is 4.7 times higher for Indians in reservation states than for the U.S. all races population. Death from chronic lever disease and cirrhosis is 3.2 times the U.S. rate as well [96]. Service Unit Director Vern Donnell estimates that 60% of the accidents requiring inpatient care for adults are due to acute intoxication [97]. Currently, only 3% of the IHS budget goes toward alcoholism [98]. Due to the extent of the problem and the numerous negative consequences of the problem, this is completely inadequate. Additional alcoholism funds are needed as well as educational, prevention, and outreach programs to combat this far reaching epidemic.

Emergency services are especially important and needed by the Native American community. One reason for this is that associated with high level of alcohol use is a higher accident rate and more murders and suicides than for groups with less alcohol consumption and abuse. In fact, complications of alcohol abuse in general cause approximately one-third of the preventable deaths in the United States [99]. This corresponds to a murder rate for Native Americans that is 6.3 times the general population and the accident death rate among IHS areas that is 3.4 times the U.S. rate [100]. In fact, among Native American men, accidents are the second leading cause of death [101].

Domestic abuse is another problem in the Native American population of epidemic proportions. It also has an elevated level of violence and crime that often requires emergency services. Native Americans make up only 6.25% of the total population of South Dakota, but 50% of the domestic abuse cases. This disproportionate amount represents, generally, the more violent cases that more frequently require medical services [102].

Another health issue is that currently located on the Yankton reservation are three sites that have been identified by the Environmental Protection Agency (EPA) as hazardous waste sites. This area is part of the Wagner Service Unit. These sites all contain pesticides that may have been disposed of improperly and represent human and environmental health threats [103]. These locations are potentially hazardous now and the health threats will increase over time until they are cleaned up. This means additional health needs exist that require attention from medical services, especially awareness and education. The reason this is just being addressed now is that "when Congress created a Superfund in 1980 to clean up hazardous waste sites across the country, it neglected to provide for sites on Indian lands" [104]. This oversight is finally being corrected.

All these interacting factors, diabetes, poor diet, high levels of other diseases, low median age for pregnancy, high infant mortality, high child morbidity, alcohol abuse, high accident rates, high domestic abuse, and high environmental health risk all increase the need for readily available, nearby medical services. Because of the severity of the current health conditions, this need is more important in this community than in most other communities. Ironically, however, this is also the community to be affected by the IHS proposed inpatient closure.

Current Health Resources

Current personnel levels are inadequate. The Wagner Service Unit has only three physicians for 7244 active patient files. This translates into 2414 patients per physician. The South Dakota ratio is over 3 times lower at 719 patients per physician and this is in a state where 42 of the 67 counties are officially listed as Health Manpower Shortage Areas (HMSA). Obviously the counties served by Wagner are among those listed as HMSA. The national average of physicians is 495 patients per physician, nearly five times more physicians than at Wagner [105]. Also, in the past some of the physicians at Wagner Service Unit had not completed their residency programs, the major part of a physicians clinical training [106]. As a result, they were inexperienced and lacking in important training for providing services to patients. This shortage of qualified doctors is probably not going to be corrected any time soon, either. Most of the physician that serve IHS are recruited through either the National Health Service Corps. or the Commissioned Corp. The former program has been terminated and the last participants will finish in 1990. The latter program "is not a growing resource" either because it is equivalent to active military duty in a time without a draft [107]. Therefore, the problem of adequately staffing IHS with qualified medical personnel is likely to increase rather than decrease in the upcoming years.

The Wagner Service Unit has three Community Health Representatives (CHR) and one Health Educator. There are clinics dealing with individual health conditions such as diabetes and prenatal care, but none of these are in the community itself. Nor do they offer any programs specifically on education or prevention. There is no prevention training or education on nutrition or sexually transmitted diseases, including AIDS. Also, there is little outreach to try to reach people or bring them into the Service Unit. Though the CHRs attempt to bring in pregnant women and a sanitation officer goes out to deal with accidents and home injuries, active intervention and inclusion of patients in their own health is sorely lacking [108]. Also, as health conditions illustrate, the current efforts are quite ineffective and extremely inadequate for the tremendous needs of the community.

Health Threats of Contracting Out and Travelling Far Distances

The physical health hazards involved with travelling to the Service Unit and travelling the additional distance from the Service Unit to the location of contracted out services are numerous. From the Wagner Service Unit to Yankton (56 miles) this means travel time of at least another hour when the road conditions and weather are good and clear in addition to the travel time to reach the Service Unit which can be up to two hours in good conditions (95 miles). Also, the geographic region of the Wagner Service Unit has unpredictable weather year round with especially severe weather during the winter season. Temperatures of 25 to 90 degrees below 0 degrees F with wind chill factor are not uncommon. At other times one must deal with severe thunderstorms and the accompanying lightning, thunder, and heavy rain. The Great Plains also have strong winds that can hinder travel, particularly at the higher speeds of the highway. Therefore, drivers must drive more slowly and cautiously. The winter brings on heavy snow and ice that also require slower, more careful driving. At times, blizzards occur and may strike suddenly which can prohibit safe travel altogether. In these cases, getting to the distant Service Units for medical care already is extremely difficult and hazardous. Adding more distance would significantly increase these problems and health consequences due to both the time factor and the travel itself.

Because of the increase in time needed to reach medical care when services are contracted out, patients can suffer additional physical trauma and complications of their injuries depending on the exact nature of each patient's condition. For example, look at medical emergencies. Often, time is crucial in these cases and delayed treatment interferes not only with the ability of medical personnel to provide the prompt treatment the patient needs, but it also compromises the usefulness of that treatment when it is administered. For instance, if someone cannot receive care quickly, bleeding and shock are more extensive and more detrimental to the patient. When treatment is finally applied, it can be less effective because the condition is more advanced, leading to a more serious health condition, longer recovery time, and more severe, prolonged effects of the injuries. These negative consequences are also more likely to be permanent when treatment is delayed. Furthermore, the worst case scenario is also possible; in the time required for travelling the additional distance, the patient could die. In the case of a pregnant woman in labor, the child can be born on the way to the Service Unit before reaching the hospital, threatening the health of both the mother and the child. Unfortunately, the latter is a quite common event. Nearly every family on these reservations can recount at least a single story of the birth of a baby before the mother could reach the hospital.

In addition to the time factor of the added travelling, patients suffer physical discomfort and can have complications due to the travel itself. Riding in a car or ambulance involves bumping and motion that can be painful and hazardous especially in the cases of broken bones or nerve tissue damage. This risk has already been accepted to a certain degree because the locations of the Service Units presently require quite extensive travel. However, as the distance increases, the associated risk also increases. No one can predict what illnesses, injuries, or conditions people may develop and exact causes cannot be definitively attributed to specific health problems. Therefore, quantitative risk analysis is not practical nor possible to determine the extent of the increase of risk due to the longer time and farther travel. Nevertheless, one can conclusively state that this risk increase does occur and this issue deserves serious consideration.

Contracting out services also has implications for the emotional health and welfare of patients. Though people are encouraged to transport themselves, transportation is provided for the patient by one of three Community Health Representatives (CHR) in a government vehicle. This means that the patient is without family and friends and their emotional support and comfort. If accompaniment is required medically, the referring IHS physician may authorize a family member to escort the patient to the site of the contracted service. When this occurs, minimal financial provisions are provided by IHS for the escort. However, this does not occur often [109].

The CHR may allow family or friends to ride along as a way to provide support and comfort to the patient in addition to providing means of getting to the Service Unit. However, this practice may be of only limited help in practical terms because of the financial burden. People accompanying the patient without medical requirement have to pay their own way entirely. The allowance for escorts generally provides for only a minimal stay near the patient at a local motel and money for food, too. These provisions for the authorized person may be inadequate to cover the entire time the patient is receiving treatment. This is especially problematic because as discussed above, the average annual income for single women is only $4623 and for a six person household is $6040 [110]. Therefore, money would probably be unavailable from either the patient, escort, or their families to supplement the allowance from IHS for the escort and the escort probably is not able to afford to stay with the patient at the site of the contracted service. Also, with the prevalent problems of unemployment, if the escort is employed she/he probably cannot afford the loss of earned income and needs to return home to avoid missing work. However, this can still be expensive as it requires multiple trips to and from the location of the contracted service. Therefore, patients usually are left by themselves because family and friends cannot afford to stay with them. Unfortunately, this financial constraint also means that the patient who is left alone at the contract service site receives no emotional support.

This problem is especially an issue for women and their newborn children. At times babies need extended hospital stays due to complications of birth, prematurity, or other health concerns. In these cases, mother/child bonding is interrupted. This interruption occurs even when the mother is still in the hospital herself and bonding is essentially prohibited if the mother is released from the hospital because of the extreme distance from home and lack of money to stay close by. Provisions for the mother to stay near her baby are only provided when doctors determine that it is medically needed [111]. Thus, this most crucial form of emotional support and bonding can be eliminated.

Presently, the medical profession has well documented evidence concerning the influence on and correlation between the emotional state of patients and their healing processes. The absence of family and friends can be deleterious to the health and healing of a patient due to the lowered emotional state that comes from being alone and feeling removed from the familiar support systems of the community. This issue also relates to the amount of trust the patient feels toward care-givers. The hospital facility, medical personnel, and general community may all be foreign to the patient and this unfamiliarity can negatively affect the health of the patient. This is especially likely if the patient has not spent much, if any, time off of the reservation. This discomfort and associated lack of trust jeopardizes the effectiveness of medical services and treatment.

Stress is another component of one's emotional state and this factor is also intensified by the unfamiliarity of the contract service environment. Stress of the escort can also affect the patient. That person may never have spent much time away from the reservation either and the more urban setting could be confusing and upsetting. Indeed, these people may not even know how to get to the hospital and going through the efforts of obtaining directions can be very stressful and trying for both the patient and the escort. Again, the attitude and feelings of those around the patient does influence that person and this effect can be negative for the health condition.

A more serious consequence of contracting out more services is that the people in need of care may not be as willing to go through the inconvenience and added expense of seeking care, especially for less pressing or seemingly trivial health conditions. The change could act as a deterrent to health care because obtaining care would be easier to put off or avoid altogether. This would allow conditions to go untreated and diseases to develop further without the intervention of medicine. Indeed, without prompt treatment, cases could deteriorate into emergencies rather than being dealt with in less hazardous stages. Injuries may not receive necessary medical treatment and could heal incompletely or incorrectly. Definitely, measures such as education and prevention would be more difficult to implement, resulting in additional and continuing health problems. Conditions that require regular care such as glucose monitoring for diabetes and pregnancy/prenatal care would also be less controlled, again leading to more serious health conditions and possible effects that could be averted with proper care and check-ups. Without prevention and interactive treatment, health conditions for the Native American population will not improve. Of course, this also assumes that funds are actually available for contract care. If not, the above negative consequences are a certainty.

Additional Concerns

The IHS proposal seems to insufficiently address some pertinent questions and concerns. For example, in the decision to contract out services particularly to the Wagner Community Hospital adequate attention has not been paid to the possibility of overcrowding. In the winter at the IHS hospital, ADPL is as high as 12 [112]. During the same time period at the Community Hospital ADPL has been 12 as well. These peak times tend to occur simultaneously in which case not enough beds would be available for all the patients requiring inpatient care. Wagner Community Hospital only has 20 beds [113]. This space problem will be especially pressing as the populations continue to increase which is one of the concerns that the Service Unit Director has expressed [114].

The issue of culture is also important. Many Native Americans have traditional beliefs about medicine and health that they combine with western medicine. Currently, as inpatients in the IHS hospital some people participate in religious and cultural ceremonies, some of which involve smoking pipes. IHS is understanding of these activities. However, these activities would not be allowed in the Wagner Community Hospital because of hospital regulations. This compromises the religious and cultural beliefs of some of the Native American patients, though to allow the prohibited activities would infringe on the rights and health standards of the other patients. Still, this is a problematic issues that has been overlooked.

Significant cultural differences do exist and need to be understood and considered more fully.

IHS is a federal program and as such is not under the jurisdiction of state laws. However, the public hospital is subject to the state rules. This fact has impact for contract patients, especially concerning such issues as AIDS and notification of partners who could be affected with the HIV virus. IHS has a policy that mandatory notification is not a requirement while South Dakota state law states that it is [115]. If services are taking place at a given facility, those laws pertain and these differences need to be considered. Without carefully examining all the possibilities and consequences of these various conflicts, privacy and discrimination problems could easily result.

The feelings of the people are significant as well. According to Service Unit Director Vern Donnell, members of the Native American community feel that IHS is their hospital and that they would not receive the same overall quality of care and variety of services if the inpatient services were contracted out [116]. In speaking personally with members of the community, most people are unaware of the IHS proposal for the closure of inpatient services. However, those that are aware are unhappy and concerned about the prospect of losing inpatient services. They fear the consequences for their health care needs.

Another consequence that seems to have been overlooked is the economic impact of the inpatient closure to the Native American community. By eliminating the inpatient facility, IHS also eliminates employment of some janitors, cooks, linen service, medical delivery and so forth. Many of these positions are held by Native Americans. Following the inpatient closure, these jobs would be cut back or even terminated.

Larger still is the potential economic impact to the Indian community related to the Indian Self-Determination and Education Assistance Act of 1975. Through that legislation, Native American tribal councils and health boards have the right to manage and control all funds received to their IHS facilities from third party sources [117]. Until now, the Yankton Sioux Health Board and Tribal Council have been unaware of this right and have not exercised it, though they plan to do so in the future [118]. Over the past three years, the amount from third party sources has varied between $420,000 and $450,000 per year [119]. This can be managed by the Native American community representatives for the health projects that are most needed and would be most effective. By controlling the necessary hiring and project development, the service community could have further control of improving their health status. However, without the inpatient hospital, this money is diminished considerably and the many possibilities are eliminated.

The practice of contracting out services is already established and many services are referred to non-IHS hospitals which affects the determination of patient enrollment. For example, because childbirth is already contracted out, two potential patients, mother and child, are not included for every birth. Over the past three years the total number referred from the Wagner Service Unit was 145 births and 290 patients [120]. This number is lower than the actual number of births, also, because some Native American women currently go through Wagner Community Hospital for childbirth using funds from Title 19. In the three year period between 1981 and 1983, Wagner Service Unit processed 278 births which represents 556 patients [121].

The possible discrepancies and underreporting of these numbers is also evident by the much larger patient numbers that come from counting the active files rather than the number of patients seen in a given year. For example, the Wagner Service Unit as of July 7, 1989, had 7244 active files but served approximately 2500 patients in 1988 [122]. Therefore, only about 35% of the population received service from the Service Unit and the number of patients who receive care represents only a small fraction of the total numbers of people who are eligible. This points out that the Service Unit is not reaching its service population. Considering the poor status of health and the fact that people do need medical attention, this is especially dangerous.

Childbirth

Childbirth is currently a contracted service to Yankton, SD which is 56 miles from the Service Unit. Combined with the distances people must travel to get to Wagner, this is several hours travel time. Again, most families have experienced births on the way to the hospital which is an extreme health hazard for both the mother and the child. There are three reasons that deliveries are not done at the Wagner Service Unit. The first is that there is no anesthetist or anesthesiologist. Second, the facility does not have an ultrasound machine which is considered necessary for JCAHO accreditation. Thirdly, common medical thought is that 100 births per year are needed in order for physicians to maintain their skills; on average Wagner has less than that. Between the years 1981 through 1983, there were 278 births for an average of 93 per year [123]. The exact number varies from year to year, however. In 1988 there were about 70 through the Yankton Service Unit [124] and several more through Wagner Community Hospital with funding through Title 19.

To deliver babies locally would greatly decrease health and safety risks for both the mothers and the children and the reasons for not providing obstetrics are correctable. Considering that contracting out to Yankton is the alternative, delivering locally is a highly desirable change. Wagner Community Hospital also contracts out obstetrics due to low numbers of births. However, between the two hospitals there are over 100 babies per year which is more than enough to justify performing them here. Both communities would benefit. Also, the IHS delivery room is kept operational because women occasionally deliver there, especially in low risk cases or those in very advanced labor. In the first half of 1989 there were three births there.

To upgrade to deliver babies in Wagner, the cost for the needed personnel would be between $40,000 to $45,000 per year and about $45,000 for the ultrasound machine [125]. These costs could be split by the Service Unit and Wagner Community Hospital and over the years these expenditures could be offset by the decreased costs of not contracting out. An average birth that is contracted out currently costs about $3500 [126]. An additional problem used to be the lack of a fetal monitor machine, however, the Service Unit now has one [127]. Thus, it is possible to have childbirth locally which would be highly useful to the community for health and safety reasons as well as convenience. It would also be long term cost effective.

Health Maintenance Organizations

Another option for dealing with the health needs of the Native American community has been suggested recently. This is to bring in a Health Maintenance Organization (HMO). Unfortunately, this idea has several critical drawbacks. An initial problem is that a facility of this type would have to come in from outside of the area, from outside of a reservation system. The people that run HMOs are, therefore, unfamiliar with the Native American community and the special needs it does have. Of course, they would learn and prepare for the specific circumstances of the reservations, but an HMO is not designed for this type of a community. We have established that the health needs in these communities are greater than health needs in other populations and that they are often more severe and require more frequent services.

The next issue concerns money. To become a member of an HMO one must pay a monthly or annual fee that entitles that person or family to medical services from that HMO facility. IHS would probably be able to only pay for basic coverage and members of the Native American community would not be able to supplement this. Considering the income and unemployment levels of the people affected, it would not be feasible. Most people cannot afford to and probably would not join a health program even if it were the only source of services available. Currently, only about 0.5% of the population has private health insurance and approximately 30% receive some health insurance as federal employees [128]. Thus, when most people needed services they would be ineligible and unable to get medical care or needed treatment.

Along this same line is the issue of mobility. The Native American community is very mobile, travelling and moving around the country a great deal. Much of this is to follow and participate in the Pow Wow, art, rodeo, and conference circuits. In addition, family members and tribes commonly travel to visit each other, to a much greater extent than the non-Indian population does. What would happen when health services were needed and people were away from home? Visitors would not be able to use the services of an HMO here because they would not be members. Current IHS eligibility allows for eligible people from one region to receive treatment at any other IHS facility. This policy would not work with an HMO because they are privately owned. All people other than resident members would be unable to receive treatment at this facility even if they were eligible for IHS elsewhere [129].

Furthermore, Health Maintenance Organizations are intended to make a profit. They operate as private companies and when they do not or cannot turn a profit they have no legal responsibility to continue providing services. They can just close and stop operating. This would be a large threat if an HMO were to come into a Native American community. With the large possibility of low enrollment along with a higher than average need for services per person, a profit might not be possible without compromising the quality of medical care. Thus, if an HMO were to stay open the services could be substandard. On the other hand, if it were to close no services would be available at all.

The Future

Since 1955 IHS has helped improve the health status of Native Americans as is their stated objective. To reverse this trend now by eliminating inpatient services in a severely medically needy community would undermine their efforts of the past and would contradict the official IHS goal. The conditions of health are abominable and need to be raised. This can be accomplished most effectively and expediently with maximum patient involvement, awareness, and education. In a recent IHS publication also under the heading, The Future, is the following statement that needs to be applied to this situation:

> "The Indian's health priorities of today... requires a partnership between the Federal Government and the Indian and Alaska Native peoples. To ensure the effectiveness of this partnership, the Indian Health Service will continue to utilize its resources to the fullest extent in order to provide quality health care, augment Indian Health manpower for Indian needs and improve Tribes' abilities to plan and manage health programs." [130]

Recommendations

1. Maintain hospital beds and continue to offer inpatient services at the Wagner Service Unit.

2. Hire additional physicians to maintain current outpatient services and increase the quality of the services.

3. Demand fully trained and experienced physicians and other health care workers.

4. Reinstate an incentive program for physicians to practice in rural/medically needy areas, specifically reservations.

5. Continue with expansion and upgrading of the outpatient facility in order to offer more comprehensive, quality services.

6. Work jointly with Wagner Community Hospital to provide local labor and delivery services at one of the two hospitals.

7. Implement numerous health education and prevention programs within the community. Specifically, the following are needed:
   a) Nutrition and food preparation workshops for diabetics and the general population stressing healthy food choices and education about the effects of food on health, like cholesterol and fats.
   b) Education on exercise and its numerous health benefits.
   c) Comprehensive outreach and intervention programs for alcohol abuse, including treatment and counseling.
   d) Education about long-term effects and related health problems of diabetes and alcohol abuse.
   e) Outreach and educational programs about sexually transmitted diseases, including AIDS. Teach people about safer sex and provide readily accessible condoms.
   f) Outreach on birth control, including alternative methods and general family planning.
   g) Education and intervention on how to have a healthy baby. Strong efforts must be made to lower the infant mortality rate.
   h) Training in natural birth methods.
   i) Parenting classes and training in child development skills for new and current parents.

j) Outreach on prevention of such treatable diseases as tuberculosis, pneumonia, and influenza.

8. Hire innovative personnel for the above programs, preferably Native American.

9. Provide means for exercise within the community, particularly in the winter, by creating and facilitating indoor options that benefit cardiovascular health and overall fitness.

10. Improve relations and communication between the Service Unit and the community it serves. Specifically, inform the community and the Yankton Sioux Health Board and Yankton Sioux Tribal Council of the proposal to close the IHS inpatient service facility.

11. Promote partnership with IHS by increasing involvement and input from patients both formally and informally. Concerning the proposal, seek responses from the community and address those concerns.

12. Require training for members of the Health Board and Tribal Council. Include general health training and education and management skills for maximizing positive use of funds through the Self-Determination Act (638). Specifically focus on how to manage funds from third party sources.

13. Purchase glucometers for patients to use in their homes to control and regulate diabetes.

14. Work more closely with the Tribal Council and Health Board on policy matters and changes.

15. Coordinate health education and prevention work with community based organizations (CBO).

16. Implement an accessible, anonymous response system for all patients to their health services. IHS should promptly address those concerns.

17. Encourage and facilitate control and responsibility of health within the service community.

18. Provide mobile clinics that travel to distant areas to offer health care.

19. Provide home health care for the special needs of the elderly and the handicapped.

20. Provide more comprehensive mental health services.

21. Improve and expand dental services to offer more complete services at the Service Unit.

22. Approach patients as whole human beings, a combination of physical and mental capacities.

23. Offer alternative treatment methods and health programs.

24. Provide diagnostic services for children, especially for learning disabilities and fetal alcohol syndrome.

Notes

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51. Conversation with Harlan Horned Eagle, Administrative Officer of Yankton Sioux Tribe and member of Tribal Health Board, Marty, SD, July 6, 1989.
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55. See note 12.
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Figure 1. See note 1.
Figure 2. See note 54.

TESTIMONY OF THE COLORADO RIVER INDIAN TRIBES BEFORE THE SENATE SELECT COMMITTEE ON INDIAN AFFAIRS

Indian Rural Health Care Hearing

March 22, 1990

The Colorado River Indian Tribes ("Tribe") appreciates the opportunity to present testimony to the Committee. The Tribe has been working since 1981 on its latest efforts to improve the facilities, and consequently, the health care provided to Tribal members. Our testimony will focus on three areas of concern to the Tribe. Our first concern is the interminable delays in getting our new outpatient, ambulatory care facility constructed. The latest of these delays is related, in part, to our second concern, the development and inclusion of a wellness center which will increase the capability to provide long term preventive health services and reduce long-term costs. The final portion of our testimony will relate our Tribe's experience and recommendations for utilizing alternative funding sources for the development and construction of Indian Health Service ("IHS") facilities. The Tribe is requesting the assistance of the Committee and Congress to bring our proposed facility into reality.

BACKGROUND

The Colorado River Service Unit ("Service Unit") has a service population of approximately 6,349 Indians in Arizona and California. The main facilities, inpatient and outpatient, are located on the Colorado River Indian Reservation. The Service Unit covers approximately 70,073 square miles. While our reservation

Indian population makes up approximately 74 percent of the total Service Unit population, this still leaves a significant number of Indians who must travel over 100 miles to receive medical care.

The inpatient facility currently has an inpatient caseload of 5.5 patients per day. This number is understated because many times persons who medically should be admitted are sent home due to a lack of registered nurses and other support staff. The inpatient facility is utilized by four tribes for primary inpatient care. The Tribe estimates that with full staffing the inpatient facility caseload would be in excess of 15 patients per day. The outpatient facility handles approximately 31,825 patients from this reservation per year and 57,790 patients in the service unit per year. This facility is the only facility our members turn to for their ambulatory care needs.

Our resources to deliver health care are physically fragmented and inadequate. These services must be consolidated and expanded in one health delivery complex in order to coordinate and make effective use of our resources. Our people experience one of the highest rates of diabetes in the Indian Health Service, yet we have no physical therapy or podiatry services available from IHS or through contract health services to provide routine care needed to prevent amputation of their limbs and assist them to care for themselves. We don't have adequate optometry services to care for their frequent eye problems. We could go on and on. We believe that this outpatient and community health construction project is our last chance to obtain the health facilities and staffing so desperately needed to care for our illnesses and keep us healthy. We believe that we have contributed materially to the delivery of care through construction of the Parker Indian Hospital inpatient space. We have patiently waited for IHS to provide the outpatient facilities needed. But instead of assistance, we have received ten years of frustration with a result that is inadequate.

NEW OUTPATIENT FACILITY

1. History of Tribal Efforts

The outpatient facility began as a new hospital and outpatient facility center in 1980. The last ten years have been a tortuous path for this project, most of which has been reported to Congress in great detail by the Tribe.

In 1981, Parker appeared on the IHS outpatient construction priority list. The Colorado River Indian Tribes, through a visit to the IHS Headquarters soon thereafter, requested involvement in the planning process. In 1982, the first construction planning document was prepared by the Phoenix Area IHS and supported by Tribal resolution. See Exhibit A.

The entire construction process has been one continuous delay. For the outpatient facility, decisions to start and stop the entire process have been made at the Headquarters level without input from the Tribe, the Service Unit or Area. There have been numerous attempts over the past ten years to construct a facility and staff using square footage and staffing that were arbitrarily arrived at by Headquarters staff, discarding the standard facility planning documents. The Headquarters staff, after mandating use of the approved planning manuals for design of facilities, required wide variances from the planning manuals for our facility. These mandated variances were not justified and did nothing but serve to delay our project. IHS then dictated that the planning manuals must be utilized thus necessitating another rewrite of the Program

Justification Documents and Program Of Requirements.

Our project also was briefly sidetracked by the GAO Study on Small IHS Hospitals. This project was intended to identify facilities where future hospital construction could be avoided because the hospitals were too small to be cost effective. In 1982, the IHS Director questioned the existence of the inpatient facility at Parker, due in part to the "GAO Report on Small IHS Hospitals". He also stated the ambulatory and community health facility ("outpatient facility") being planned for construction would eliminate the possibility of replacement of the inpatient facilities. A similar position was again taken by IHS late last year, but was not formally communicated to the Tribe.

The Indian Health Service has since viewed the GAO report as a mandate (or opportunity) to close these small hospitals, a conclusion never addressed in the GAO intent or report. Within the past year IHS Headquarters has developed a policy of closure of all inpatient facilities of less than 15 beds. This policy was developed without tribal consult, and cannot be justified either by quality of care or financial reasons.

The Parker facility changed from construction of a hospital and outpatient facility to just outpatient. It has been put on hold numerous times by Headquarters personnel for a myriad of reasons. An engineering study has been conducted and recommended replacement of the 60-year old facility. A review as conducted by the Director of the Gallup Indian Medical Center ("GIMC") at the request of Dr. Rhodes, and the GIMC Director recommended construction of an outpatient facility and continuation of inpatient care. Dr. Rhodes then issued a letter supporting this position. See Exhibit B. However, within the past several months, the Headquarters Director of Health Programs has once again placed a hold on the project due to questions of the continuation of inpatient services. See Exhibit C. The most recent delay was initiated without consultation with CRIT and will most likely place our facility "out of sync" with other IHS construction projects, and will likely delay the project another year. The Tribe understands that Headquarters Facility Construction staff will not even discuss our project with Area staff, let alone allow progress of the paperwork.

The Parker Outpatient Facility construction project demonstrates the most flagrant use of over-planning and over-studying we have ever observed. The money in staff time spent on this project in the last ten years, and the inflation experienced in the project must be astronomical. Those paying the most severe penalty, however, are our people who still do not have an outpatient center physical plant and staffing that meet their health care needs.

It has taken over ten years and we are still at least two years or more away from having the much needed outpatient facility constructed. There have been about 20 complete rewrites of the planning manuals for this project. Even though Congress appropriated $647,000 in architectural and engineering funds for this construction project in FY-88, not a dollar has been expended. Local IHS staff revise the plan for the facility pursuant to the direction of Headquarters staff. This is usually done with only 24-48 hours allowed for making such revisions. Headquarters then delays reviewing the changed plan until enough time has passed that another revision is necessary due to passage of time. Such revisions include modifications necessitated by a change in the caseload numbers. One begins to believe that

Headquarters is waiting for the facts to change so it can decline to build the facility.

Despite an early commitment by IHS to involve the Colorado River Indian Tribes in the planning and design of our new facility, IHS Headquarters routinely requests rapid turnaround on each new major revision of the planning documents (there have been over 20). The result is that we are involved only after the planning documents are completed by Phoenix Area IHS. When we have gone on record as supporting a planning option, our voice is disregarded by IHS Headquarters.

Our observation of the IHS construction process has taught us a classic lesson in bureaucratic bungling and delays. We have seen over 20 major revisions of the planning documents, two Headquarters staff visits to Parker, a feasibility study in 1982, a Deep Look Survey in 1986, an engineering study in 1987, and innumerable visits by Area Planning personnel. All this has taken place over ten years, and we have just this month seen a routed planning document. What is the result of all the years of studying and planning? All previous work is discarded for space and personnel figures that are based on the opinion of the IHS Director rather than on the objective planning documents IHS has pledged to Congress to use. Perhaps IHS has the funds and staff to waste on such endeavors, but we are not willing to play such foolish games with the health of our people. Neither are we naive and unable to understand the complexities of construction of health facilities, having completed successfully the existing Parker Indian Hospital inpatient space from concept to construction in much less than three years.

The Tribes, after seven years of frustration in dealing with the IHS in the planning of a new ambulatory and community health care facility, request the assistance of Congress to complete the project and serve the health care needs of our people.

WELLNESS CENTER

Significant in the outpatient facility planning has been the development of the Wellness Center. This Wellness Center is developed in response to a request by Dr. Rhodes and in response to the Congress in the Indian Healthcare Improvement Act Amendments. See Exhibit D. The result of the Wellness Center work at the Colorado River Service Unit has resulted in increased interest by other service units in the Phoenix Area. The Tribe would like to see the proposed Wellness Center included in its outpatient facility. We believe it will be more cost effective to construct the ambulatory care and Wellness Center in a coordinated fashion. The Tribe is aware that keeping the Wellness Center as part of its outpatient facility could create further unreasonable delays. Because of the importance of the outpatient facility, not to diminish the importance of the Wellness Center to the Tribe, we are willing to separate the two aspects of the proposed project.

If the Tribe must separate the two aspects of the project, the Colorado River Service Unit Wellness Center should be funded as a demonstration project added on to the Parker Outpatient facility. Colorado River is a good location for establishing a Wellness Center. The local IHS staff and the Tribe's Department of Health and Social Services have been promoting wellness to the community for quite some time. For example, a successful nutritional weight loss program has been offered to community members and staff. To date, 64 persons have enrolled and there is a long waiting period. The Tribe has also started a community wide program to curb alcohol and drug abuse.

The proposed Wellness Center will provide services to eligible community members with special emphasis on the following high risk groups: youth, diabetics, hypertensives, obese, those with cardiac disease and others with high risk lifestyles. A draft description of the Wellness Center is attached as Exhibit D. The facility as proposed by the Tribe would provide services such as individual counseling, group and individual activities in the exercise fitness area such as aerobics, weight lifting and jogging. The Wellness Center would provide nutrition services including individual assessment and counseling and group weight loss activities. Physical examinations, including routine lab analyses, stress testing, isokinetic testing, body composition analysis, nutritional analysis and health risk appraisal will also be conducted to develop individual prevention strategies. Cardio-vascular disease, diabetes, hypertension and orthopedic disease and trauma will be targeted for rehabilitation through physical therapy, exercise and diet management.

A community health risk appraisal which will be a survey of individual behavior will be undertaken to identify intervention priorities and assist in evaluation of the over-all success of the wellness program over several years. A health education program will be developed to increase the awareness of community members of behavioral intervention strategies. The Wellness Center will "market health".

We believe that the activities undertaken through the wellness center will reverse long term health problems of our Tribal members. The only way to prevent the devastating impacts of advance stages of diseases such as diabetes and alcoholism is to begin prevention before the diseases take hold. This will necessitate a reversal of long standing practices and behaviors. There needs to be a reeducation of the community. The benefits of following healthy lifestyles must be presented to the community until such lifestyles become second nature. The Wellness Center programs will be attempting to reverse decades of poor health practices.

Importantly, a significant benefit from the wellness approach will be reduced long term health costs. Today's health care costs are astronomical. This result is that Indian health care, which historically has lagged behind that of other Americans, will further suffer. The wellness approach of addressing and treating diseases and practices which, if unaddressed, will lead to major long term health care costs is a crucial step to get the health care costs under control and to improve the quality of life for our Tribal members.

The Tribe would like to see the Wellness Center included as part of its outpatient facility and architectural and engineering work to commence immediately. In the alternative, the Tribe would like Congress to provide funding to allow our Tribe to develop a demonstration project for wellness centers. Much of the necessary groundwork for the wellness center concept has already been completed. The Tribe will provide any additional information the Committee may need to respond to this request. The wellness approach is key to the quality our Tribe's long term health care.

ALTERNATIVES FUNDING OF HEALTH FACILITIES

The Tribe is a prime example of how tribes and communities can positively participate in funding the construction of health care facilities. Construction at Colorado River of our inpatient facility shows that the most useful and cost effective facilities have significant design and construction input from local health care providers, managers and the Tribe.

In 1982, the IHS Director questioned the existence of the inpatient facility, due in part to the GAO report. Through the presentation of accurate and timely information, we convinced Congress and GAO to remove objections to construction. Our Tribe then devoted $440,000 of our HUD Community Development Block Grant funds to replace the inpatient space of the Parker Indian Hospital. This replacement of inpatient space was completed in December 1985 and offered to IHS, but the IHS Director refused to accept it. This refusal stemmed from concerns about meeting all IHS criteria. The Assistant Secretary of Health and Human Services finally accepted the construction gift from the Tribe. While there were some problems, this is one example of how creative solutions to the health care facility needs on reservation can be addressed. It should be noted that this inpatient facility was constructed at one-half the then IHS construction cost and in a fraction of the time needed by IHS to plan and construct facilities.

CONCLUSION

We request the support of Congress to obtain a new free-standing outpatient and community health care facility at Parker to be constructed adjacent to the existing inpatient facility. The Tribe would like to see a wellness center included in this facility. If this is not possible, the Tribe requests that Congress fund a wellness center demonstration project at the Colorado River Service Unit. We also request to be included in the approval of the planning, design, and construction of our health facilities.

We have included in our testimony supporting documentation for your review and study. Thank you for allowing us the time to present our needs and we will be happy to answer any questions you may have.

r\IHStest.

Resolution No. R-38-82 ⑭

RESOLUTION

COLORADO RIVER TRIBAL COUNCIL

A Resolution to Conditionally approve of the Program Information Document for new facility on the Colorado River Indian Reservation

Be it resolved by the Tribal Council of the Colorado River Indian Tribes, in regular meeting assembled on May 8, 1982

WHEREAS, the Colorado River Indian Tribes is a federally recognized Tribe, duly organized with a Tribal governing body, known as the Tribal Council, according to the provisions in the Indian Reorganization Act of June 18, 1934, and

WHEREAS, the existing Indian Hospital (Public Health Service) at Parker, Arizona, was built in 1930, and

WHEREAS, the Indian Health Service Facility Priority System has placed the Ambulatory Care portion of the existing facility in high priority for new construction,

NOW, THEREFORE, BE IT RESOLVED that the Colorado River Indian Tribes endorse and approve construction of a new Ambulatory Care Unit, provided portions of the existing hospital could be remodeled as proposed in the Program Information Document,

BE IT FURTHER RESOLVED that the Colorado River Indian Tribes desire to have the new Ambulatory Care Unit built in close proximity to the existing facility to provide an opportunity to share some services,

The foregoing resolution was on May 8, 1982 duly approved by a vote of 8 for and 0 against, by the Tribal Council of the Colorado River Indian Tribes, pursuant to authority vested in it by Section 1.v. Article VI of the Constitution and By laws of the Tribes, ratified by the Tribes on March 1, 1975 and approved by the Secretary of the Interior on May 29, 1975, pursuant to Section 16 of the Act of June 18, 1934, (48 Stat. 984). This resolution is effective as of the date of its adoption.

COLORADO RIVER TRIBAL COUNCIL

By Anthony Drennan Jr.
Chairman

Elliott L. Brett
Secretary

: October 25, 1988

: Director

: Parker Health Care Facility

: Director
Phoenix Area

THIS LETTER
ESTABLISHED DR. RHOADES'
CONCURRENCE WITH BUILDING
AN OUTPATIENT FACILITY AT
PARKER - See attached
chart for more
info.

In May 1986, as part of an Area review, the IHS Executive Review Team determined that: (1) the recently remodeled Parker ambulatory care area and the new 20-bed inpatient wing of the Parker IHS Hospital were adequate to meet the present health care needs of the Indian people of the Colorado River Indian Tribes (CRIT) Service Unit; and (2) provision of a new replacement facility, although desirable to achieve optimum health care delivery, would not represent a high priority usage of limited IHS health care facility construction funds when compared to other more urgent health facilities needs. Therefore a decision was made to renovate the existing structure, correct many of the structure's deficiencies (both in the inpatient and outpatient areas), add 13,000 square feet of additional space, and expand the staff of 56 employees by 12 positions. The total cost for this work was estimated at $6.9 million and a recurring budget increase of $0.5 million was also projected.

The 1986 decision proposed to leave the inpatient portion of the renovated facility intact but recommended long-term cooperation with the Parker Community Hospital which is also a relatively underutilized inpatient facility. There was concern that the average daily patient load at the IHS hospital had decreased to such an extent that the quality of inpatient service to the Indian people of the CRIT Service Unit could not be ensured because the workload was such that the medical staff was unable to sustain many potentially critical inpatient care skills. Major factors affecting the IHS Executive Review Team's determinations were: (1) the CRIT indicated a very strong preference to retain the existing inpatient capability; (2) additional space and resources would be required to correct building deficiencies and to support the new, 20-bed inpatient wing just constructed with a $400,000 Housing and Urban Development grant to the Tribe; and (3) the projected staff increase from 56 to 122 employees, at an added annual recurring cost of $2.95 million, was not evaluated to be urgently needed.

2/23/89 MC

EXHIBIT "B"

This past summer, at your request, I agreed to review the 1986 decision. I asked two IHS consultants to visit the facility and report their findings to Headquarters, IHS. Both consultants identified deficiencies in the existing facility and recommended a new free-standing outpatient facility to optimally deliver ambulatory services.

One consultant was informed, during his review, that the actual staffing level of the Service Unit is 84 positions as compared to the 56 authorized positions shown on previous staffing schedules. This higher level of staffing may explain the Service Unit's apparent ability to meet the medical care needs in a seemingly adequate manner during the 1986 review.

One consultant recommended discontinuing inpatient services at Parker because more adequate capabilities to deliver the acute care presently provided by the IHS Hospital at Parker exist in the Blythe, Lake Havasu City and Parker Community Hospitals. The consultant reported that all uncomplicated deliveries already go to the Blythe Hospital and complicated deliveries go to the Phoenix Indian Medical Center. Furthermore, the community hospitals at Blythe, Lake Havasu City, and Parker have occupancy rates of less than 50% and are located within reasonable distances according to IHS access standards. The consultant noted that IHS policy would not permit construction of an inpatient component in a health facility without special justification if alternate services are available.

To an extent, the consultants have confirmed that the original 1986 decision was based upon a reasonable evaluation of the apparent adequacy of the existing facilities and staff. The consultants did not report findings of overworked staff, an inability of staff to treat patients, or other indicators that the facility or the staff presently are not meeting the medical care needs of the Indian people in the Service Unit. One consultant noted that during his review of the Parker facility he had not observed the large "crush of humanity" typical of many older IHS facilities, where patients are often seen standing in hallways, lying on gurneys, and sitting in wheelchairs waiting for services.

However, IHS/HQ staff has given extensive consideration to the new information and the consultants' recommendations for construction of a new free-standing outpatient facility. They concur that a new free-standing outpatient facility would consolidate components of the ambulatory care program and would permit their more effective and efficient operation in conjunction with the community health programs. The 84 employees actually on-board is a significant increase from 56 positions indicated in earlier program documents so the recurring cost increase for a new facility would not be as great as originally calculated, particularly with the addition of the 12 positions recommended by the 1986 Executive Review Team. At this time, replacement rather than renovation of the existing outpatient facility appears to be a better long-term solution for the CRIT Service Unit's health program.

The IHS/HQ staff cannot endorse new space or staff to support inpatient services at the Parker IHS Hospital at the present time. Current and proposed IHS policies and modern medical care trends do not justify operation of small rural hospitals with low occupancy rates. This issue centers on the need to ensure delivery of quality health care and is compounded by possible poor utilization of limited financial resources.

Would the structures be requested by the Tribe for a health-related purpose? There will be substantial costs for renovation of the structures if future use is anticipated. The IHS should identify these needs as part of the total cost of the project.

After a review of all available information and staff recommendations, I am willing to consider another option for the Parker facility and I ask that you present and discuss this option with Tribal officials. This option entails construction of a new and expanded, free-standing outpatient facility with provision for dietary services. The IHS will recommend staffing increases for ambulatory, community health, and other non-inpatient related program components utilizing the IHS resource requirements methodology (RRM) as a guideline. As with all new facilities, adjustments may be recommended based on the existing workload, current staffing, etc.

All small under-utilized IHS inpatient facilities, including Parker, will be evaluated during the next year to determine if the inpatient services component should remain open. This evaluation and the possible phase-out of inpatient services at small under-utilized inpatient facilities will be consistent with current and proposed IHS policies and will permit the IHS to comply with the one-year advance notification requirement imposed by the Congress. While the proposed IHS policy is based on quality of health care considerations a policy of this nature has been recommended strongly by the General Accounting Office of the U. S. Congress and by other organizational components that monitor IHS activities. The IHS is trying to implement the policy in a manner oriented appropriately to health care priorities before we are directed, or forced, to take more severe measures for economic reasons.

The proposed new outpatient facility as envisioned in the new option, would be located adjacent to the inpatient wing in such a manner that the inpatient services can be discontinued at a future date without adversely influencing the effectiveness of the outpatient program. The Phoenix Area should also apply appropriate IHS criteria to the Parker facility PJD prior to implementation of any additional renovation work on the inpatient wing. The IHS should not renovate a facility with excess capacity. Another issue to be addressed in the PJD for the construction of a new free-standing facility is the future use of the existing structures.

I understand the desire of most communities to retain inpatient services; however, we are finding that in many instances we can provide more, and better quality, health services to Indian people by contracting with the private sector for inpatient services, as we are already doing extensively in the CRIT Service Unit.

In the past few years the IHS has given increasing priority to health promotion and disease prevention. We would like to pursue this programmatic emphasis through the wellness-center concept and the option discussed above could [illegible] exciting opportunity to emphasize the wellness center concept in a [illegible] expanded health program for Parker. After you have had an opportunity to review this matter with the Tribe, please arrange a telephone conference call or meeting with appropriate IHS/HQ staff so that we may reach a final decision regarding the most acceptable course of action to follow.

/s/
Everett R. Rhoades, M.D.
Assistant Surgeon General

Prepared by:BFPearson/pak/10-13/#3260t

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Indian Health Service

Memorandum

Date .DEC 27 1989

From Associate Director
Office of Health Programs

Subject Parker PJD and POR

To Associate Director
Office of Environmental Health & Engineering

In October 1988 Dr. Rhoades wrote to Mr. Don Davis, Director, Phoenix Area, approving the development of a PJD and POR for a replacement "free standing" health center to be attached to the current inpatient facility. No space or staff to support inpatient services were to be included except for dietary. There was extensive discussion about discontinuing inpatient services at small, underutilized facilities which had reasonable alternative hospitals to provide inpatient care.

Since that time Dr. Rhoades has approved the "Standard for an IHS Inpatient Facility" which requires a report by the end of fiscal year 1991 justifying continuing inpatient services at any facility with an average daily patient load (ADPL) of less than 15. Before proceeding with review and evaluation of the PJD and POR, it is essential that the Phoenix Area evaluate whether inpatient services should be offered at Parker, consistent with the above policy. The draft PJD and POR have been developed on the assumption that inpatient services will be provided. This is evident from the inclusion of the following:

- o radiology, and presumably laboratory, inpatient workload is used in the development of space for these departments,
- o the pharmacy concept of operations mentions the unit dose drug distribution system and the intravenous admixture program,
- o inpatient beds are used to justify a physical therapy department,
- o projected inpatient days are used to plan supply space.

If inpatient services are to be offered at Parker, then planning space as they have done is reasonable. However, since present policy dictates that they are to evaluate the facility for potential closure in the near future, such an evaluation and decision should be effected before embarking upon a construction program.

John [illegible]
[illegible]

EXHIBIT "C"

Wellness Center

The Director of the Indian Health Service instructed the Phoenix Area Office in December 1988 that the new Parker Ambulatory Care Center was to include, among other components, a Wellness Center. Since a Wellness Center can include a myriad of services the Parker Facility Steering Committee, composed of Area, Service Unit and tribal members studied the issue. Many discussions took place and many questions were asked. The committee visited the Aerobics Center in Dallas, Texas and received a day of instruction and guidance from Dr. Cooper's staff. Next they visited the Wellness Center at Zuni, New Mexico in order to see another model. They met with Dr. Craig Vanderwagen, OHP, IHS to present their findings. It is the hope of the Phoenix Area that the Parker Wellness Center will prove to be a worthy prototype for future centers in the Indian Health Service. The proposed program has the input from and concurrence by the Area Health Promotion/Disease Prevention Office.

Parker is a good location choice for such a center since the hospital staff has been promoting wellness to the community for some time. A successful nutritional weight loss program has been offered to community members and staff. To date 22 persons have enrolled and there is a long waiting period. A community-wide program to curb alcohol use has been started. The hospital was one of the first in the Phoenix Area to prohibit smoking in the building. The Wellness Center will provide services to eligible community members and employees with special emphasis on the following high risk groups:

Youth
Diabetics
Hypertensives
Obese
Those with cardiac disease
Others with high risk lifestyles

It will provide the following services:

1. Exercise/fitness individual counseling, group activities, and individual activities including aerobics, weight lifting, and jogging.

2. Nutrition services including individual assessment and counseling and group weight loss activities.

3. Community Health Risk Appraisal (Survey of individual behavior) to identify most common high risk behaviors. This information will be used to identify interventive priorities and assist to evaluate over-all success of the program over several years.

4. Health Education/Health Marketing will be provided to identify behavioral intervention strategies ("marketing health") for the program.

5. Physical Therapy will be provided to aid in evaluation and rehabilitation of cardiac and orthopedic patients.

6. Physical Examination to include routine lab analyses, and physician exam, but also to include:

EXHIBIT "D"

- stress testing
- isokinetic testing
- body composition analysis
- nutritional analysis
- health risk appraisal

7. Rehabilitation to include physician prescribed physical therapy, exercise, and diet management along with periodic assessment of patient status. The following target diseases will be targeted for rehabilitation:

   - cardio-vascular disease
   - diabetes
   - hypertension
   - orthopedic disease and trauma

The Wellness Center will operate autonomously from the hospital except for the tie-in with Physical therapy.

Staffing

Director

- Conduct individual and group surveys to determine wellness services needed and target populations.
- Determine service "menu" to meet wellness needs.
- Staff and equip the Wellness Center.
- Evaluate the effectiveness of wellness services and the performance of Wellness Center employees.
- Coordinate Wellness Center services with those of other tribal community agencies - stimulate wellness activities and services.
- Conduct QA of administrative and management services.
- Establish a method of evaluating Wellness Center program effectiveness.
- Coordinate Wellness Center services with other local IHS services.
- Balance the "medical" and "Community" wellness services.
- Assure proper "PR" for wellness services in the Community.
- Coordinate Wellness Center services with other Service Unit HP/DP efforts.

Physicians (2)

- Schedule and conduct stress testing.
- Establish wellness diagnostic and treatment protocols.
- Conduct quality assurance of medical services and report these activities to the Medical Care Evaluation Committee.
- Share "on-call" duties for the Emergency Room.
- Diagnose the wellness status of individual patients and prescribe wellness activities to improve the wellness status.
- Advise community and tribal groups about wellness activities and services.
- Analyze community Health Risk Appraisal data to assist in determining Wellness Center services.
- Coordinate isokinetic testing and body composition.

- Prescribe and coordinate the nutrition therapy, physical therapy, and exercise therapy to facilitate the rehabilitation of cardiovascular disease, diabetes, hypertension, and orthopedic disease.
- Conduct physical exams for special groups.
- Provide wellness education for local health care professionals and other special target groups.
- Design community wellness screening activities and coordinate them.
- Design and implement an employee health plan for IHS and other local employers as requested.

Counselor/Exercise Psychologist

- Counsel each patient regarding a menu of fitness activities to meet individual needs.
- Design group fitness/wellness activities for special target populations.
- Conduct isokinetic testing and body composition analysis.
- Manage the exercise portion of rehabilitation therapies to include cardiovascular disease, diabetes, hypertension, and orthopedic disease.
- Advise tribal/community/educational programs regarding safe and proper conduct of services.
- Provide exercise education for local health professionals.
- Participate in community wellness screening activities.

PT Aid

- Under supervision of the physical therapist, manage the physical therapy portion of rehabilitation of cardiovascular disease, diabetes, hypertension, and orthopedic disease.
- Participate in community wellness screening activities.

Clerk

- Routine clerical support of Wellness Center staff.

Nutritionist

- Counsel individuals as referred by Wellness Center staff regarding proper nutrition.
- Conduct weight loss groups.
- Consult with tribal/community groups and schools regarding special nutritional programs.
- Conduct group counseling regarding proper nutrition.
- Participate in community wellness screening activities.

Exercise Coord/Fitness Counselor

- Conduct group fitness/wellness activities.
- Schedule the use of Wellness Center exercise equipment.
- Coordinate fitness and Wellness Center activities with other community/tribal programs.
- "Sell" physical fitness activities by making them fun.
- Develop and coordinate a group of fitness volunteers throughout the community to conduct aerobics, etc.
- Provide exercise education to individuals and groups.
- Participate in community wellness screening activities.

DRAFT

III. Facilities Summary Data

A Site Survey Report is included at Tab E.

Departmental Space Requirements:

	Department Net Square Feet (DNSF)	Department Gross Area (DGSF)		Floor Gross Area (FGSF)
Diagnostic Services	3,660	5,154	x 1.2	6,185
Ambulatory Services	14,280	18,212	x 1.2	21,854
Administrative Services	10,568	12,547	x 1.2	15,056
Support Services	11,970	13,329	x 1.2	15,995
Wellness Center	4,444	5,536	x 1.2	6,643
TOTAL	44,922	54,778		65,733
Major Mechanical Space				7,888
Building Gross Area				73,621

The projected schedule for the proposed facility based on the IHS Facilities Planned Construction Budget is as follows:

Design completion	December 1991
Construction begin	March 1992
Construction completion	March 1993

According to the IHS Budget Cost Estimating System the phasing will be as follows:

Phase I
Phase II
Phase III
Total

IV. Quarters for Staff

Quarters will be required and will be computed later for Quarters Priority List.

DRAFT

WELLNESS CENTER 60.0

CONCEPT OF OPERATION

The Wellness Center will provide services to eligible community members from all five Service Unit tribes and employees with special emphasis on the following high risk groups:

Youth
Diabetics
Hypertensive
Handicapped
Obese
Those with Cardiac Disease
Others with high risk lifestyles

It will provide the following services:

1. Exercise/Fitness individual counseling, group activities, and individual activities including aerobics, weight training, and jogging.

2. Nutrition services including individual assessment and counseling and group weight loss activities.

3. Community Health Risk Appraisal (Survey of individual behavior) to identify most common high risk behaviors. This information will be used to identify interventive priorities and assist to evaluate over-all success of the program over several years.

4. Health Education/Health Marketing will be provided to identify behavioral intervention strategies ("marketing health") for the program.

5. Physical Therapy will be provided to aid in evaluation and rehabilitation of cardiac and orthopedic patients.

6. Physical Examination to include routine lab analyses, and physician exam, but also to include:

    - stress testing
    - isokinetic testing
    - body composition analysis
    - nutritional analysis
    - health risk appraisal

7. Rehabilitation to include physician prescribed physical therapy, exercise, and diet management along with periodic assessment of patient status. The following diseases will be targeted for rehabilitation:

    - cardio-vascular disease
    - diabetes
    - hypertension
    - orthopedic disease and trauma

DRAFT

The Wellness Center will operate autonomously from the hospital except for the tie-in with Physical Therapy department.

Clients will enter and sign in at the reception area. These visits may be for individualized testing, examination or counseling or to participate in an individual or group exercise program.

DESIGN NOTES

The Wellness Center should be located adjacent to Physical Therapy since the staff and function of the two departments depend upon one another. The Wellness Center must have its own exterior door. Aside from Physical Therapy there are no other necessary physical links with other hospital departments.

The exercise area and weight room should have rubberized flooring material and must be able to bear increased weights of people, exercise machines and free weights.

Staffing Requirements:

	Current Authorized Positions	Additional Required Positions	Total (Amb.) RRM Requirement	Current Inpatient Positions	Total Facility Positions
Director	0	1.0	1.0	0	1.0
Physician	0	2.0	2.0	0	2.0
Counselor/Exercise Physiologist	0	1.0	1.0	0	1.0
Physical Therpay Aide	0	1.0	1.0	0	1.0
Clerk/Typist	0	1.0	1.0	0	1.0
Nutritionist	0	1.0	1.0	0	1.0
Exercise Coordinator/ Fitness Counselor	0	1.0	1.0	0	1.0
TOTAL	0	8.0	8.0	0	8.0

DRAFT

WELLNESS CENTER 60.0

60.01 Lockers - Male/Female
Number of Users X 6 = 720

60.03 Toilets - Male
Number of Male Users $\frac{120}{2}$ = 60

Components

W.C.	Lav.	Urinals	Room	Total
4	3	2	1 @ 164	164

60.04 Toilets - Female
Number of Female Users $\frac{120}{2}$ = 60

Components

W.C.	Lav.	Room	Total
5	4	1 @ 160	160

60.05 Showers, Male

Components	Room	Total
3 @ 20	1 @ 60	60

60.05 Showers, Female

Components	Room	Total
3 @ 20	1 @ 60	60

WELLNESS CENTER 60.0

SPACE ALLOCATION WORK SHEET

Criteria Number	Space Description	Components	Area	Total
A.	PUBLIC FACILITY AREA			
60.01	Lockers, Male		1 @ 360	360
60.01	Lockers, Female		1 @ 360	360
60.03	Toilets, Male		1 @ 164	164
60.04	Toilets, Female		1 @ 160	160
60.05	Showers, Male	3 @ 20	1 @ 60	60
60.05	Showers, Female	3 @ 20	1 @ 60	60
TOTAL UNIT NET SQUARE FEET				1,164
NET-TO-GROSS CONVERSION FACTOR				1.15
TOTAL UNIT GROSS SQUARE FEET				1,339
B.	EXERCISE/EXAM AREA			
60.06	Exercise Area		1 @ 600	600
60.07	Weight Room		1 @ 600	600
60.08	Equipment Storage		1 @ 300	300
32.03	Exam Rooms		3 @ 110	330
52.01	Unit Supply and Filing		1 @ 100	100
TOTAL NET SQUARE FEET				1,930
NET-TO-GROSS CONVERSION FACTOR				1.30
TOTAL UNIT GROSS SQUARE FEET				2,509
C.	ADMINISTRATIVE/CLASSROOMS AREA			
44.03	Classroom		2 @ 300	600
41.02	Office, Director		1 @ 120	120
41.03	Office, Open Plan	2 @ 80	1 @ 160	160
41.03	Office, Open Plan	3 @ 60	1 @ 180	180
41.11	Computer Space	1 @ 20	1 @ 20	20
45.01	Waiting Area		1 @ 60	60
52.01	Unit Supply anf Filing		1 @ 90	90
41.15	Duplicating Equipment/ Supply		1 @ 80	80
54.01	Janitor's Closet		1 @ 40	40
TOTAL NET SQUARE FEET				1,350
NET TO GROSS CONVERSION FACTOR				1.25
TOTAL UNIT GROSS SQUARE FEET				1,638
TOTAL DEPARTMENT GROSS SQUARE FEET				5,536

Include
Kitchen Lab

Testimony of First Nations Financial Project
Hearing before the Senate Select Committee on Indian Affairs

March, 1990

This testimony is presented by First Nations Financial Project on behalf of the **Brotherhood Community Health Clinic in the Porcupine District of the Pine Ridge Indian Reservation South Dakota**. This testimony documents barriers encountered in the development of community health care on rural Indian reservations. We support changes through legislative initiatives which would allow Native American communitites to develop innovative and cost effective health care systems in their communities.

American Indian communities have been distressed by high levels of economic, social and health problems for many years and are faced with a long and difficult path to the recovery of their once self-sufficient way of life. First Nations Financial Project is dedicated to helping tribes find and succeed on this path. In our work, we recognize the need to support cultural, human, and economic vitality. To this end, our projects seek to support traditional tribal and extended family structures, provide opportunities for Indian entrepreneurs to increase income, build tribal management skills, and facilitate innovative community development efforts.

Today, the size and range of health care problems among Indian people has reached shocking proportions. There can be no question that their need for high quality and accessible health care is both substantial and urgent. The Indian Health Service (IHS), the federal agency mandated to provide health care to all Indian people, is clearly not up to the challenge facing it. Its budget has not kept pace with the rate of this nation's rising health care costs. And like facilities in other rural areas throughout the country, IHS has been unable to attract enough health care professionals to fill the already too few positions it has available.

Added to these general problems are handicaps inherent in IHS's management and organizational structure. Because of it's top to bottom managment style and structure, IHS does not easily adapt to changes in the health care needs and preferences of its patient population. IHS operates in relative isolation from other medical or educational organizations, (public or private) and lacks the flexblility to intergrate into other health service systems. It therefore fails to keep up with new trends in health care delivery and does not become sensitive to gaps and overlaps in health care and related services being provided both on and off the reservation.

The failure of the Indian Health Service to provide adequate health care for the Porcupine District on the Pine Ridge reservation led to the formation of the Brotherhood Community Health Board (BCHB). Established in 1982 to design, build and operate a comprehensive community controlled health care facility for the nearly 3,000 residents of the Porcupine District, the BCHB's vision was to have a health center which would provide quality care and elevate the health status of the residents of their community.

At first, the BCHB approached IHS with their idea for a clinic and requested construction funds. Citing limited funds for facility construction and an existing construction priority list, the IHS denied the BCHB's request for construction funds but agreed that if the community would construct the facility, IHS would provide the staffing. The BCHB proceeded to organize and construct a clinic facility which would be the center of their health care services. Construction began in 1985 and, with funds from public and private grants, the clinic was completed in February 1989.

To gain a comparison, federally-funded IHS health facility construction projects are 10 to 13 years in the identification, approval, appropriation, planning, design, and construction. A small six member community board of concerned citizens, the BCHB was able to do in six years what it takes the Federal government 10 to 13 years to do. The Kyle Health Clinic on the same reservation, was identified as one of IHS top priorities in 1981 and was completed 5 months after the BCHC at an estimated 57% more per square foot. Tribes and Indian people should not have to wait this long for health facilities, what is deemed a priority in 1981, is an outrage to Indian people 9 to 10 years later. The BCHB refused to wait and have been penalized for taking control of their own health care.

With their new clinic completed, the BCHB was ready to move into operational stages. However, it was at this time that the IHS, citing its $45 million budget shortfall for FY 1989, reneged on its agreement to staff the clinic. When it became apparent that IHS would be unable to provide for the Brotherhood Clinic's staffing needs, First Nations worked with the BCHB to develop a new strategy for operating the clinic that would provide immediate medical services within the newly constructed facility.

The first step was to re-negotiate a new MOA which would enable the IHS field health clinics to move from a nearby day school to the new facility. This agreement enabled an immediate success towards the long-range goal of a full-service clinic and put the clinic building to use.

The BCHB new strategy is to complement the activities of the IHS. In doing so, the BCHB expects to introduce certain innovations in the delivery, management and financing of health care delivery to Indians on the reservation that would not only increase the quantity and quality of services but would achieve significant cost savings over the current system. It was further hoped that these innovations would have wider application than the Pine Ridge Reservation and would eventually constitute a model that could be replicated on other reservations. The innovations are as follows:

(a) Establish an accepted role for a community controlled and operated clinic within the exsisting IHS health delivery system on the reservation. The Brotherhood Clinic will coordinate with the IHS Service Unit on a variety of levels, including medical record keeping, professional consultation, hospital privileges, hospital admittance and discharge, medical supplies, equipment repair and maintenance, radiology, laboratory and pharmacy, etc.

(b) Construct a modern, energy efficient health and dental clinic facility using public and private funds other than those from the IHS's national construction budget. The Brotherhood built a 7,140 square facility for $435,000 or about $61 per square foot - a rate that IHS has not been able to match.

(c) Bring additional sources of funds for health services and related social and educational services onto the reservation to increase the quality and quantity of care and support being provided to Indian people. These additional sources will include private foundations, Medicare and Medicaid, and other federal, state and county programs.

(d) Achieve a lower cost per patient visit than IHS is able to obtain, given its higher program and facility operating costs. IHS currently bills Medicare and Medicaid at $76/visit and is believed to operate at even a highe per patient visit cost than this figure.

(e) Obtain Rural Health Clinic (P.L. 95-210) certification by virtue of operating in a rural medically under-served, manpower shortage area and by using middle level, and less costly, health care professionals (i.e. nurse practitioners and physician assistants). This special certification will enable the clinic to receive "full-cost reimbursement" from Medicare and Medicaid for clinic visits and home visits.

(f) Establish a reservation-wide Home Health Care Services program to provide homebound people essential medical and other clinical support services which enable them to remain in the home and avoid costly institutional care as long as possible.

(g) Serve non-Indians as well as Indians residing in the area. Also, coordinate with off-reservation as well as on-reservation health, social and educational institutions and programs to ensure patients maximum continuity of care in the community.

(h) In future negotiations with IHS, establish a formula and procedure whereby IHS covers the Brotherhood's costs of providing health care services to tribal members who do not qualify for Medicaid and Medicare reimbursement. IHS could reimburse the Brotherhood at a fixed rate per patient visit (possibly using the rate Medicare and Medicaid establishes with the Brotherhood Clinic). Or, IHS could enter a yearly contract to provide an amount based on a projected patient load multiplied by a yearly average number of visits.

We would like Congress to take a look at this innovative project for long term solutions to immediate and critical problems in providing health care to Native Americans. The BCHB represents the cutting edge of reservation development and self-sufficiency as it relates to health care. Because BHCB is ahead of their time, they are being penalized for their innovations and are unable to gain cooperation from the Indian Health Service. While long term solutions are being examined our immediate request to Congress is to;

1) Direct IHS to negotiate a contract with the Brotherhood Community Health Board to provide health services to tribal members (not eligable for M/M.)
2) Direct IHS to provide funds to purchase medical equipment for the BCHC.
3) Direct IHS to provide overhead costs for clinic operation of the IHS field health clinics.
4) Direct IHS to work with tribes or community groups on innovative health projects in a cooperative manner.

The BCHB embarked upon a risky venture to meet the health needs of the surrounding community. Critical unmet health needs were recognized and the community took action to address the problem. While federal support was needed, it was not the level that would have been required had the facility been constructed and staffed by the IHS. Many difficulties arose from this self-determination effort, the most critical being the lack of support from the IHS. Congress and the IHS need to recognize and develop the methods and systems by which to support and promote these tribal and community models. Joint ventures between tribes, Indian communities and the IHS could be explored and promoted. The BCHB maintains their commitment to seeing the project through to fruition. Many hurdles exist but with a high level of dedication and a commitment from Congress to provide assistance, the dreams of the BCHB will become a reality.

HISTORY OF DEVELOPMENT FOR BROTHERHOOD COMMUNITY HEALTH CLINIC:

The narrative submitted outlines the history of the Brotherhood Board in the development of their health program. A new strategy was adopted last May, 1989 when the Brotherhood, frustrated with IHS and desperate to get the clinic operational developed this new program for health delivery. This series of events also documents the obstacles encountered when a community group attempted to work within the current IHS system

1982: Establishment of Brotherhood Community Health Board as a result of a Needs Assessment Study which revealed a critical need and desire for the health care by residents of the Porcupine District on the Pine Ridge Reservation.

1982-1986: Developmental funding successfully pursued and secured for entire design and construction of clinic.

1986, February 19: Oglala Sioux Tribe passes resolution of support for the development of the Brotherhood Community Health Clinic.

1986, September: Dr. Terrance Sloan, Aberdeen Area Director, appointed a task force, chaired by current Pine Ridge SUD, John Gobert. Task Force composed of other IHS employees, Oglala Sioux Tribe, and Brotherhood Community Health Board. Purpose of Task Force was to negotitate "Buy Indian Contract". Areas to be addressed: funding level for BCHB, how BCHB would intergrate its functions with IHS, Medicare and Medicaid reimbursements, referral capability between the clinc and IHS system.

1986, November 3: Task force meets and Memorandum of Agreement signed. Agreement outlines positions which would be assigned to Brotherhood Clinic via the Pine Ridge Service Unit. Also refers to the funding associated with assigned medical positions, laboratory and radiology services, maintenance and service budget for dental equipment, medical supplies and also promises to provide funding for stated items with a total budget commitment of about $629,187.00

1986, November 28: Letter written to Audrey Nora, Regional Health Administrator DHHS from Dr. Terrance Sloan, Director Aberdeen Area IHS stating support of Brotherhood Clinic. This letter and MOA were documents utilized to obtain construction funds for the clinic from DHHS office in Denver, Colorado

1988: Construction money runs out. First Nations Financial Project conducts site visit with MacArthur Foundation to the Pine Ridge Reservation. Program Officer from MacArthur expresses interest in project and agrees to fund the final construction of clinic and technical assistance via First Nations Financial Project.

1988, Fall: Warren Means, Project Consultant anticipates completion of clinic and approaches local IHS for fulfillment of 1986 Memorandum of Agreement. Mr. Means is unable to gain commitment or cooperation from local IHS officials and has no knowledge IHS may not be able to follow through on commitments.

1989, January: High level meeting between IHS, First Nations, Brotherhood Administrator, Oglala Sioux Tribal President, Senator Daschle's office, at IHS headquarters, Rockville, MD to discuss the 1986 MOA. Warren Means again requests funding and support for the clinic. Commitment is ignored by IHS, but an offer is made to transfer equipment from a Rosebud Reservation facility to the Brotherhood clinic. One IHS staff person makes suggestion to her management that "IHS needs to develop policies and procedures for dealing with community based clinics." This later proved to be the only significant point made during this high level and expensive meeting.

1989, February: Construction completed on Brotherhood Community Health Clinic. This state of the art facility is 7,140 square feet with construction costs under $500,000. The community has a new health care facility, but no information as to when services will be provided.

1989, February through March: Series of three high level meetings between IHS officials, First Nations, Brotherhood Administrator and Representative from Senator Daschle's office to seek funding and assistance in accordance to 1986 MOA. Suggestions made by IHS to seek assistance are either administratively incorrect, procedurally impossible or agreed to by IHS without any follow through. The Brotherhood Board begins to realize that the federal government will once again fail to live up to it's commitments and the community continues to wait for much needed health services.

1989, April: Dr. Everett Rhoades, Director of IHS finally sends a letter to the Brotherhood Board indicating IHS will not be able to extend assistance to the Brotherhood Community Health Clinic. This is the only notice the Brotherhood receives from IHS indicating they will not be able to fund the clinic.

1989, May: First Nations and Brotherhood Board attend retreat in Rapid City, SD to discuss development necessary so services can be provided in the new clinic. A entire new clinic development strategy is discussed and adapted due to the failure of IHS to meet promises.

1989, June: Meeting held in Rapid City with representatives from IHS, Brotherhood Board, Senator Daschle, Congressman Tim

Johnson, First Nations, Oglala Sioux Tribe to re-negotiate a new MOA to move the IHS Field Health Clinics from the day school to the new Brotherhood facility. New working relationship is defined between IHS and the Brotherhood Board.

1989 July: New MOA signed. IHS Field Health Clinics begin in the new Brotherhood Community Health Clinic. IHS cannot committ "additional" resources to Brotherhood Clinic, so the Brotherhood agrees to provide the clinic rent free to IHS in exchange for moving the current field health clinics from the day school to the new facility. IHS agress to pay for overhead bills associated with operating field health clinics.

1990 January: Local Brotherhood Board and Administrator call on IHS to pay for bills associated with the Field Health Clinics. It is at this time, IHS announces the current MOA is not a "legal" document.

1990, March 16: Due to the lack of cooperation with IHS, another meeting is called with same participants of June 1989 meeting. Payment associated with the last 8 months of IHS Field Health Clinics is requested at this meeting. IHS informs BCHB they cannot be reimbursed with MOA since it is also not a "paying document". A "service contract" is needed for payment. Another MOA is negotiated at this meeting, the service contract must be deferred to another meeting on March 20.

1990, March 20: meeting held at IHS clinic to negotiate "Service Contract". New MOA is voted on and approved by Brotherhood Board and agreement is made regarding floor space to allocate for billing purposes. IHS comes back with a figure of 37% for overhead payments even though they are currently utilize 80% of the building resources.

1990, March 29: Brotherhood Board finally recieves check, 8 months after the second MOA is agreed to and fours years after the original MOA is negotiated. Chairman Homer Kills Back rushes payments to prevent the disconnection of heat and phone.

MOA to move the IHS Field Health Clinics from the day school to the new Brotherhood facility. New working relationship is defined between IHS and the Brotherhood Board.

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1990, March 29: Brotherhood Board finally recieves check, 8 months after the second MOA is agreed to and fours years after the original MOA is negotiated. Chairman Homer Kills Back rushes payments to prevent the disconnection of heat and phone.

ATTACHMENTS OF SUPPORTING DOCUMENTATION:

A) Resolution of tribal support
B) Planning Status Report
C) Letter to Audrey Nora, DHHS with original MOA
D) Letter to Everett Rhoades
E) June 1989 meeting agenda, results and list of participants.
F) Draft MOA from June 1989 meeting
G) Memo regarding meeting on March 16, 1990 with list of participants.

RESOLUTION NO. 86-24

RESOLUTION OF THE OGLALA SIOUX TRIBAL COUNCIL
OF THE OGLALA SIOUX TRIBE
(An Unincorporated Tribe)

ATTACHMENT A

RESOLUTION OF SUPPORT FOR THE BROTHERHOOD COMMUNITY HEALTH BOARD.

WHEREAS, members of the Brotherhood Community of Porcupine District have formed the Brotherhood Community Health Board, and

WHEREAS, the Brotherhood Community and the Porcupine District Council has gone on record in support of the Brotherhood Community Health Board, and

WHEREAS, the Brotherhood Community Health Board is in the process of developing a comprehensive, community based outpatient clinic to provide health care services to members of the Porcupine District and surrounding communities, and

THEREFORE, BE IT RESOLVED, that the Oglala Sioux Tribe goes on record in support of the Brotherhood Community Health Board in its development efforts for a comprehensive outpatient clinic, and

BE IT FURTHER RESOLVED, that the Oglala Sioux Tribe supports the Brotherhood Community Health Board by resolution, and

BE IT FURTHER RESOLVED, that the Oglala Sioux Tribe directs the Indian Health Service to provide assistance and support to the Brotherhood Community Health Board for the development of the comprehensive outpatient clinic so long as this assistance does not hinder the overall hospital operation and services; no records will be taken from the Pine Ridge Public Health Service hospital.

C-E-R-T-I-F-I-C-A-T-I-O-N

I, as undersigned, Secretary of the Oglala Sioux Tribal Council, hereby certify that this resolution was adopted by the vote of: 18 for; 0 against; and 1 not voting, during a Regular Session held on the 18th day of February, 1986.

Eileen H. Iron Cloud
Secretary
Oglala Sioux Tribe

A-T-T-E-S-T:

Newton Cummings
President
Oglala Sioux Tribe

Received
FEB 19 1985
Pine Ridge
Agency

ATTACHMENT "A"

ATTACHMENT B

PLANNING STATUS REPORT

December 1986

Planning Task One: To negotiate and receive funding approval through a "Buy Indian Contract", with the Indian Health Service in Aberdeen (Area IHS Office), under "Health Services", for a multi-year (3 year) contract for operation of the planned Porcupine Health Center Out-patient Clinic.

Status: On September 17, 1986, the IHS Area Director, Dr. Terrence Sloane, appointed a Task Force, to be chaired by John Gobert, Pine Ridge Service Unit Director and made up of Area level contracts personnel, Oglala Sioux Tribal Chairman appointed by Joe American Horse, Oglala Sioux Tribal Chairman and Brotherhood Community Health Board appointed by Homer Kills Back, BCHB Chairman. The following individual made up this Task Force:

IHS

John Gober, IHS-SUD - Pine Ridge, Task Force Chair
Mr. Henry Bowker, PMO, Hospital & Clinics
Mr. Steve Scheverman, Community Health Nursing
Mr. Roger Condon, 638 Program Laison Officer
Mr. Archie Clifford, Area Contracting Officer
Mr. Gordon Wilcox, PMO, Facilities Management

Oglala Sioux Tribe

Mr. Paul Iron Cloud, Oglala Sioux Tribal Vice-President
Mr. G. Wayne Tapio, Chairman Oglala Sioux Tribe Health, Education, & Welfare Committee

Brotherhood Communtiy Health Board

Mr. Warren Means, Administrative Consultant
Mr. Ted Means, Board Member and Oglala Sioux Tribal Council Representative, Porcupine District

The purpose of the Task Force was to negotitate the BCHB "Buy Indian Contact"? in the following manner:

1. Come up with a funding level for the BCHB, which would include an assessment of potential shared services between the IHS and our clinic, as well as liability and supply costs. local
2. Determine how the BCHB Health Center would integrate its function with the over-all health delivery system to Pine Ridge, by IHS and the estimated Third Party Revenue to support the Clinic (Medicaid/ Medicare). local
3. Establish effective referral mechanisms between this clinic and IHS for a unified health care system. - local

See attached copy of IHS Area Director Memorandum, September 17, 1986. The Task Force met twice, October 20, 1986 and November 3, 1986. The following are the funded items under the contract to BCHB:

IHS M/M (Medicaid/Medicare) positions:

Physician Assistant GS 11 (1)	$26,381	
OB/Gyn Nurse Practitioner GS 12 (1)	$31,619	
Clinical Registerd Nurses GS 9 (2)	$43,608	
Laboratory/X-ray Technican GS 7 (1)	$17,824	
Medical Records Techicians GS 4 (2)	$25,724	
Dental Assistants GS 4 (2)	$25,274	
Community Health Nurses GS 9 (2)	$43,608	
Total IHS M/M funded positions to BCHB		$214,488
IHS Positions Directly Funded		
Pharmacist (under contact) GS 11		26,381
OB/GYN Consultant	(approximate value)	130,000
Pediatric Consultant		
Nurse Midwifery Consultant		
Dentist		
Laboratory/Radiology Medical Consultants		61,200
Total Staffing Funded by IHS		$432,069
Maintenance/Service for Dental Equipment		3,600
Supply Cost		219,898
Total IHS Funding of Personnel & Supplies		$655,568

(refer to attached copy of November 28, 1986 letter by the IHS-Area Director, Dr. Terrence Sloan, - November 21, 1986 letter from J. Mike Wood, Program Manangement Office Health Systems Planning).

The Buy Indian Contract Negotiation is completed with $655,568 in medical personnel and clinic supplies funded relative to our clinic operation, for a multi-year contract. Annual budget to begin in this Fiscal Year 1986 - when the facility is completed May 1987. It is too premature to provide the names of the individuals who will fill these positions, as the funding has just been approved.

Planning Task Two: To extensively research, identify and secure funding under other federal and state programs we may be eligible for, towards a multi-year plan. An example is the Federal Surplus Property Program, which we will apply to and are eligible for, for clinic equipment.

Status: On October 1, 1986, we were notified by Howard B. Kelly, Director, Grants Manangement, Department of Health and Human Services (DHHS), Region VIII, Denver, we have a fundable application. Warren Means had met in September with Dick Bohrer, Director General, Health Services Delivery, DHHS in Washington and was assured by Mr. Bohrer, that if our application met the technical criteria, funds would be made available. Following serveral phone meetings, Barbara Bailey, Director of the Division of Health Service Delivery, DHHS, Region VIII, Denver, requested on December 5, 1986 the BCHB to submit a budget modification prioritizing the needs not met by IHS under 3 areas:

1)	Building Renovation Costs	$170,400	
2)	Administration and Operational Clinic Costs	229,081	
3)	Rural Health Initiative - 1 Dentist 2 Physicians	130,000	?

Warren Means submitted the budget modifications December 9, 1986. Barbara Bailey will send us a formal grant award letter on these costs by mid-January. A copy of the budget modification and breakouts for both of these areas are attached. When we receive the Grant Award letter formally committing those funds, a copy will be forwarded on to the Bush Foundation and other pending funding organizations. Because we now have a completed IHS Buy Indian Contract, we are processing our Federal Surplus Property Equipment Collection through the South Dakota Surplus Property Program. In our August 14, 1986 Planning Report, the Buy Indian Contract had to be completed before we could began collection of equipment. We are also pursuing funding for 2 State of South Dakota Programs from the SD Dept. of Health: ? when is it?

(1) Maternal Child Health Program and (2) Home Health Care -? Program. The reason the DHHS $170,400 is being called "renovation" is because DHHS is currently under a congressional moratonum on new health facilites construction, but can provide "renovation monics" to already

existing facilities. Since we have the entire exterior building up, we can receive the funds.

Planning Task Three: To identify and secure non-governmental funding which will fill in the necessary monies not met by Tasks 1 and 2. total - ?

Status: We have pending planning grants to complete Planning Tasks Two, Three, Five, Six, Seven, Eight, Ten and Eleven and to phase-in the Administrative portion of the Clinic. These Tasks were dependent upon completion of the Buy Indian Contract and the DHHS Funding, which took more time to complete than we had earlier anticipated. Once we receive the formal award letter from DHHS in January 1987, we can began completing the tasks. The Pending Planning Grants are:

Agency	Amount	Date of Determination
United Methodist Church Women's Division	$22,000	March 1987
Northwest Area Foundation	15,000	February 1987
Presbyterian Church US Women's Opportunity Giving	8,700	April 1987
MS Foundation	7,500	Spring 1987
American Lutheran Church Development Assistance	7,500	February 1987
Needmor Fund	15,000	February 1987
Total Pending:	$75,700	

? which were applied for? -

NOTE: The budget also includes $15,000 for the 1st Year Facility Utilities. A copy of the pending Budget is attached.

On May 2, 1986, the Oglala Sioux Tribe approved a 24 year lease of 2.5 acres of Tribal Land of the BCHB Clinic Building and Programs. On June 2, 1986, the BCHB Construction crew began construction on our 7,140 square foot building. Cost projections for the building are estimated at $50/square foot, at a total cost of $357,000.00. We have raised and spent $112,937.75 in construction materials and labor with funds from Foundations and individual donors. Currently there remains a balance-to-raise of $244,062.25. With the expected DHHS Renovation grant of $170,400.00 there remains a balance of $73,662.25 needed. It must be noted here, that the IHS and DHHS funding are contingent upon a completed facility. Three major capital foundations have been approached for construction funds. The Kresge Foundation, of which we requested $65,000, turned us down October 20, 1986 because "the number of applications submitted to the Foundation each year, far exceeds our funding capability". The Burlington Northern Foundation, of which we requested $50,000, turned us down November 10, 1986 because again, "the requests always far exceeds the limits of our resources". We currently have a proposal yet pending with the Chevron Funds, for $50,000. Frankly, we are not expecting a favorable response, as their letter, September 4, 1986 indicates. While not a denial, that state the drop in oil prices severly puts a decrease in available constribution funds, but have referred our request to their Regional Funding Program. If the Bush Foundation would consider a construction grant of $71,400 (20% of our $357,000 over-all constuction costs), we could complete the building late May 1987. A few pictures of the Clinic Facility Construction are enclosed. We have a Clinic Equipment Proposal yet pending with the SEVA Foundation, for particular pieces of equipment not available under the Federal Surplus Property Program.

Planning Task Four: With information gathered from Tasks 1, 2, and 3, we will complete a Projected Income for a multi-year Outpatient Program. [illegible]

Status: In lieu of the positions and supplies funded by IHS (outlined earlier under Planning Task One), we have completed Projected Income from IHS. ? while Based upon the DHHS, Health Services Delivery indication of funding committment ofr the 3 categories outlined in Planning Task Two and upon receipt of our expected Grant Award Letter in January, we can formally complete a fully projected income for a multi-year Outpatient Program. Our projected Medicare/Medicaid — when is projection Projected Revenue in the first year, will go into a special revenue account to be used in Operational Costs for the 2nd year and soforth each year.

Plannign Task Five: To advertise through existing medical publications and medical networks, through recommendations and inquired interest, for applicants to apply and be hired in the approval staff positions. To interview and select from the applications, 7 WIC [illegible]

the medical personnel and submit their credentials for certfication.
Status: Not done yet. Upon DHHS Funding Notification, we can began conducting this task.

Planning Task Six: To clear all medical personnnel contracts through the Aberdeen Area IHS, the DHHS, the SD Board of Medical Examiners and the SD Dept. of Health in the certification process.
Status: When Task Force is completed, we will conduct this task.
[illegible]

Planning Task Seven: Develop a Clinic Medical Operating Plan in planning and a final schedule of health delivery, once the staff are a board and submit these to the DHHS - Survey and Review Branch for clinic certification. Receive certification as an Outpatient Clinic.
Status: When Task Six is completed, we will conduct this Task. [illegible]

Planning Task Eight: Apply for a medicaid/medicare provider number, enabling the BCHB clinic to collect reimbursements for medical services under these programs. fiscal
Status: When Task Seven is completed, we will conduct this task. [illegible]

Planning Task Nine: Develop and set up Fiscal and Administrative procedures contract compliance, cash flow projections, payroll, accounts payable/receivable, all tax reports (federal and state), maintenance of bookkeeping procedures, procurement and property management and billing that must be approved by IHS and DHHS.
Status: Completed under the direction of the BCHB Certified Public Accountant (CPA), Mr. Francis Killer. - ? [illegible]

Planning Task Ten: Develop patient medical recordkeeping system, which must meet approval by IHS and DHHS. Receive approval from IHS, in the coordination of medical records, referrals, and admitting agreements. [illegible]
Status: Addressed and completed by the IHS,BCHS,OST,DHHS Task Force under "Memorandum of Agreement" currently being processed.

Planning Task Eleven: With medical staff, develop quality control procedures that meet with approval of the Denver DHHS,IHS,SD Dept. of Health, which is required by Medicaid and Medicare.
Status: Radiology and laboratory consultants to over-see quality control have been approved by the IHS contract. This task must

have already been completed along with Planning Task Eight, in order to receive a provider number.

The time-line for completion of these Tasks (contingent upon the funding received on schedule from DHHS) is July 1987. Upon com-completion, we will open the clinic in our 7,140 square ft. Facility, with medical staff, programming, and services to conduct primary care, preventative care and health education in a coordinated and comprehensive fashion.

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ATTACHMENT C

November 28, 1986

Our Reference: AO-D

Audrey Nora, M.D.
Regional Health Administrator
DHHS, Region VIII
1961 Stout Streets
Denver, CO 80294

Dear Dr. Nora:

Please note the attached memorandum addressed to Mr. Means from W. J. Gobert, Service Unit Director, Pine Ridge Hospital, reflecting the commitment of various health professionals to cover specialty clinics at the Porcupine facility. Also note that the Indian Health Service would provide laboratory and radiologic services as well as the supply costs as detailed in the attached supply costs for the Porcupine Clinic.

It is the impression of our Area that the active operation of this clinic would decrease the demand on our primary facility at Pine Ridge as well as provide enhanced access for patients who live in the Porcupine area. Upon evaluation of the Reservation health care system, it was clear to our health professionals that the Porcupine location is ideal from a logistics as well as a demographic standpoint.

I hope you realize this involves a significant commitment from the Indian Health Service to the survival and existence of this clinical operation. We are doing this because there is, in fact, a tremendous need for health care for the Oglala Sioux people. I would certainly hope that funding can be made available through your Departments to assist in the success of the Porcupine Clinic. If there are any questions I can answer regarding this memorandum or other correspondence dealing with this clinic, please do not hesitate to call me.

Sincerely yours,

Terrence W. Sloan, M.D.
Director
Aberdeen Area Indian Health Service

Attachment

cc: Mr. W. Means, Chairman, Porcupine Health Board
Mr. J. Gobert, SUD, Pine Ridge

DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE
PINE RIDGE, SOUTH DAKOTA

November 12, 1986

Mr. Warren Means
Brotherhood Community Health Center Project
P. O. Box 99
Porcupine, S.D. 57772

Dear Mr. Means,

During our meeting with Dr. Sloan and his staff on Monday, 11-3-86 in Aberdeen, South Dakota the following staffing pattern was discussed relative to the start up of the Brotherhood Community Health Center Project.

These positions as listed below would be funded by Medicare/Medicaid funds and would be assigned to the Community Health Service component of our program. As such, they would also be utilized in other Health Centers depending upon specific needs.

We would also assign various health professionals to cover speciality clinics once the Center is operational.

IHS M/M funded positions:

Physician Assistant GS-11 (1)	$26,381.
OB/GYN Nurse Practitioner GS-12 (1)	$31,619.
Clinical Registered Nurse GS-9 (2)	$43,608.
Laboratory/X-ray Tech GS-7 (1)	$17,824.
Medical Records Technicians GS-4 (2)	$25,724.
Dental Assistants GS-4 (2)	$25,724.
Community Health Nurses GS-9 (2)	$43,608.

= $214,488

The Pharmacist position would have to be contracted for. This would be closely coordinated with Mr. Arachie Clifford, Area Contracting Officer. The estimated cost for this service would be at the GS-11 level or $26,381. per year.

The PHS Indian Hospital, Pine Ridge, S.D. would also provide the following specialists to the Clinic:

[illegible] - 65 OB/GYN Consultant
[illegible] 65 Pediatric Consultant
[illegible] 65 Nurse Midwifery Consultant
[illegible] 65 Dentist

Approximate Value $130,000 annually

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NOV 17 1986
Director's Office

There would be no cost associated with these positions as they are already on-board and are paid by Pine Ridge.

In regard to the medical consultation services for Laboratory and Radiology, there would be no cost as our Hospital currently contracts for both of these services as required by J.C.A.H. Your projection of $61,200. for these services would be absorbed by the Service Unit.

November 12, 1986
Page 2.

Approximate Value - $3,600

The maintenance and service budget for dental equipment can be handled by our Bio-Medical personnel from Rapid City. The Radiology and Laboratory service contract could be funded from your anticipated Medicare collections.

$219,898.69

The various supply costs for the clinic are addressed in Mr. Wood's memo of November 3, 1986. A copy is attached to this letter.

Thank you and the other members of the Forcupine Community.and the Oglala Sioux Tribe for your interest in health and we look forward to working closely with you in the future.

W. J. Gobert
Service Unit Director

WJG:emb

cc: Dr. Terrance Sloan
Mr. Paul Iron Cloud
Mr. Ted Means
Mr. G. Wayne Tapio

Enclosure:

Funded Positions	$214,488
Specialists (approx)	130,000
Consultation Serv.	61,200
Maintenance & Serv.	3,600
Supply Costs	219,899
TOTAL	$629,187

$156,000 - Barebones Budget. FY-90
(1) MD
(1) MR
Pharmacy

DEPARTMENT OF HEALTH & HUMAN SERVICES

Memorandur

Date November 3, 1986

From Program Management Officer
Health Systems Planning

Subject Supply Cost - Porcupine

To W. John Gobert
Service Unit Director
Pine Ridge, South Dakota

The information regarding projected supply cost of the planned Porcupine Clinic follows:

SERVICE POPULATION
(Extracted from the Proposal Section Future Funding, Table 8)

	1	2 1/
Porcupine	1500	
Kyle & Outlying Areas	1800	
Manderson	744	
Wounded Knee	292	
Batesland & Wakpamni	290	
TOTAL	4,626	2,826
FY-1986 Utilization Rate	X 4.7	X 4.7
Projected Potential OPV:	21,742	13,282
Probable FY-1987 Supply Unit $:	X 7.78	X 7.78
Projected Supply Resource Need:	$169,152.76	$103,333.96
Retail Cost Factor:	X 1.3	X 1.3
Non-Gov. Resource Need:	$219,896.59	$134,334.15

1/ Excludes Kyle from Service Population.

S. Mike Wood

RECEIVED
NOV 06 1986
P.H.S. INDIAN HOSPITAL
Pine Ridge, South Dakota

ATTACHMENT D

FIRST NATIONS FINANCIAL PROJECT
69 Kelley Road • Falmouth, Virginia 22405 • (703) 371-5615

June 7, 1989

Everett R. Rhoades, M.D.
Director, Indian Health Service
Parklawn Building
5600 Fishers Lane
Rockville, MD 20857

Dear Dr. Rhoades;

Enclosed is a letter designating the Brotherhood Community Health Clinic as a "priority project" under the BHCDA criteria guidelines. We were advised by Elsie Sullivan to obtain a letter from your office and submit it with our proposal.

It is our hope that you will act on this immediately. The original time line for action from IHS in regards to the Brotherhood Clinic was 30 days from a meeting which was held on January 24. Since that time, we have received conflicting information from IHS as to the proper procedure for applying for this "special pool" of funding.

The original directive to us was that Dr. Sloan would develop the "criteria" to give to Dr. Permision so he could release an "RFP" to the Brotherhood. We waited and waited, and could not receive any movement on the so called "RFP". Finally we became too frustrated, and contacted BHCDA directly. The information we received in regards to applying and receiving the funding through the "IHS Priority Designated Projects" was not in any way similar to the procedure that IHS had indicated to the Brotherhood Administration or First Nations Financial Project.

Because we have been waiting for directives from your office, we now find ourselves in a severe time constraint. We currently have less then one month to develop and write a comprehensive proposal to submit to BCHDA. Our deadline to submit this proposal is July 1 and so we need this letter signed before that time.

We appreciate your immediate attention to this project and we are looking forward to opening the Porcupine Community Health Clinic in the near future.

Sincerely,

Andrea Lynn Smith

Andrea Lynn Smith
First Nations Financial Project
Project Consultant, Brotherhood Community Health Board

cc: Senator Thomas A. Daschle, South Dakota
Mr. R. Bad Moccasin, Legislative Assistant
Mr. H. Kills Back, Brotherhood Community Health Board
Representative Tim Johnson, South Dakota
Ms. Libby Conrad, Legislative Assistant
Warren Means, Administrator, Brotherhood Comm. Health Board

Oglala Sioux Tribe
Phone (605) 867-5821
Box H
Pine Ridge, South Dakota 57770

Office of the President

President
Paul Iron Cloud
Vice President
Harold Dean Salway
Secretary
Nancy Hussman
Treasurer
Charmaine Wisecarver
Fifth Member
Frank Marshall

ATTACHMENT E

Oglala Sioux Tribe Health Meeting
10:00 AM - June 21, 1989
Black Hills Training Center
Rapid City, South Dakota

A-G-E-N-D-A

Opening Prayer	Webster Two Hawk Rosebud
Welcome - Opening Remarks & Introduction of Guests	Paul Iron Cloud President Oglala Sioux Tribe
Remarks by H.E.W. Committee Chairman	Warren "Bim" Pourier
Status of IHS Budget	Dick Bad Moccasin Senate Select Committee Indian Affairs
Remarks by Brotherhood Community Health Board Chairman	
Update/Report on Financial Status of the Brotherhood Community Health Clinic	Staff of First Nations, Inc., Falmouth, VA -Andrea Smith -Warren Means
Remarks by the Oglala Sioux Tribe Health Board	Arta Carlow Chairperson
Remarks by Aberdeen Area Office Representative	Jayme Longbrake Executive Officer
Remarks by IHS Hospital Administration, PR	Representative of SUD's Office
Discussion on Brotherhood Community Health Clinic	Group Discussion
Closing Remarks	Paul Iron Cloud President Oglala Sioux Tribe

DEPARTMENT OF HEALTH, AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
ABERDEEN AREA INDIAN HEALTH SERVICE

COPY

OFFICE OF EPIDEMIOLOGY
MATERNAL AND CHILD HEALTH
PUBLIC HEALTH ADVISOR

Date: June 28, 1989

From: Medical Epidemiologist

Re: Memorandum of Agreement
Brotherhood Community Health Clinic and
Pine Ridge Service Unit

To: George Howell, SUD, PRSU
Homer Kills Back, Chairman of Board
Terrance W. Sloan, MD, Area Director
Paul Iron Cloud, Tribal Council President

As discussed at our June 23, 1989, meeting, our office revised the MOA as agreed. I also added the last paragraph as a suggested way to encourage an amiable ongoing relationship between the two parties. The dental program also made a few changes in the list of equipment and supplies.

Please sign four (4) originals and forward all four to the next party. Send them to Dr. Sloan last so his office can distribute the original copies (one to each of the four signatories).

If any party requests changes, let me know and we can revise and redistribute.

Thomas K. Welty

Thomas K. Welty, M.D., M.P.H., Medical Epidemiologist

RECEIVED JUL 15 1989

DEPARTMENT OF HEALTH, AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
ABERDEEN AREA INDIAN HEALTH SERVICE

OFFICE OF EPIDEMIOLOGY
MATERNAL AND CHILD HEALTH
PUBLIC HEALTH ADVISOR

DATE: July 10, 1989

FROM: Medical Epidemiologist, AAIHS

RE: Porcupine Clinic Memorandum of Agreement

TO: Terrence W. Sloan, M.D., Area Director, AAIHS

On June 21, 1989, a meeting was held at the Black Hills Training Center with the following individuals:

Paul Iron Cloud, Chairman, Oglala Sioux Tribe
Dick Bad Moccasin, Aide, Senator Daschle
Andrea Smith, First Nations Financial Project
Steve Helgerson, First Nations Financial Project
Jayne Longbrake, Executive Officer, AAIHS
Gordon Wilcox, Facilities Management
[illegible] Hutchinson, Program Planning
Jeff Hagen, DDS
Nancy Riefel, DDS
Thomas K. Welty, M.D., M.P.H., Medical Epidemiologist, AAIHS
Warren Means, Executive Director, Brotherhood Board
Board Members from the Brotherhood Board

There was no representative from the Pine Ridge Service Unit and later Mr. Howell stated that he was not aware of the meeting taking place and apologized for not being present. John Jantz, M.D., Acting Clinical Director called me on the morning of the 21st and also expressed regret that the service unit was not knowledgable in time to send a representative. The draft memorandum of agreement prepared by the Pine Ridge Service Unit was reviewed and revisions were suggested. The group agreed to hold a follow-up meeting on June 23, 1989 at 1:00pm in the Porcupine and to arrange for the Service Unit Director to attend that meeting.

A revised draft memorandum of agreement was prepared and discussed in detail at the meeting in Porcupine Clinic on 6/23/89 and final concensus was reached as reflected in the attached document. Essentially the existing services will be transferred to the Porcupine Clinic effective July 10th and dental services will be transferred when the necessary equipment for a two chair clinic is in place and operations..

Mr. Howell agreed to develop an accounting system that would identify the third party funds collected from the Porcupine Clinic operation and to utilize those funds to enhance services provided through the approved M&M plans, taking into account the need to offset costs of existing services and administrative overhead. Essentially, this will provide incentive to the Porcupine Clinic to agressively pursue third party collections.

DEPARTMENT OF HEALTH, AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
ABERDEEN AREA INDIAN HEALTH SERVICE

OFFICE OF EPIDEMIOLOGY
MATERNAL AND CHILD HEALTH
PUBLIC HEALTH ADVISOR

Page 2
July 10, 1989
Memo -

I recommend that such a system be developed in all of our service units that have outlying field clinics and that billing clerks be assigned to work in the clinics on a regular basis to encourage patients to apply for Title 19 or Medicare in that way to increase our third party collections and enhance services in all IHS field clinics. This procedure has been effective in terms of increasing service unit billings and extending that rationale to the field clinics would result in increased collections. Even if the field clinics were to receive only a percentage of collections (i.e., 50%), I'm sure that the overall amount collected would increase and improved services would be available in those clinics as a result.

I am pleased with the progress that was made at these two meetings in terms of initiating services in the new clinic and I am hopeful that we will be able to utilize the new clinic for our cardiovascular/cancer research project. The Brotherhood Board has identified a husband and wife nurse practitioner team that is interested in working at the clinic. The husband, Raymond Hogan is a Family Nurse Practitioner who I could hire through the NIH Research grant funds to conduct the research at Porcupine and possibly Manderson. The wife, Patricia Riley is a Pediatric Nurse Practitioner and she also attended the meeting on June 23 as part of her site visit to determine whether they will be working in Porcupine. She subsequently decided not to work there so further recruitment efforts will be needed.

Ted Means suggested at the conclusion of the meeting on June 23 that appropriate press coverage be obtained to announce the signing of this historic agreement and that the official signing take place in an appropriate ceremony.

In order to facilitate cooperation between the 2 agencies, I included regular quarterly meetings of the 2 agencies directors to review the memorandum of agreement and discuss potential problems before they become big problems.

Thomas K. Welty

Thomas K. Welty, M.D., M.P.H., Medical Epidemiologist, AAIHS

cc: George Howell, Service Unit Director, Pine Ridge
    Warren Means, Executive Director, Brotherhood Community Clinic
        Board
    Esther Anderson, M.D., Acting, PMO, AAIHS
    Dave Spence, M.D., Clinical Director, Pine Ridge
    Gene Sterritt, DDS, PMO, Hospitals & Clinics, AAIHS
    Jeff Hagen, DDS., Deputy Chief, Dental Service
    Nancy Reifel, DDS, Chief of Dental Prevention Services
    Gordon Wilcox, Facilities Management Branch, AAIHS
    Jayme Longbrake, Executive Officer, AAIHS
    [redacted], First Nation Financial Project
    Dick Bad Moccasin, Aide, Senator Daschle

TKW:mb:TWM0628MM:1-2

Attendance @ Meeting

Name	Organization
Richard Bad Moccasin	Senate Select Comm. Ind Aff.
Nancy Reifel	Aberdeen Area IHS Dental Prog.
Jeffrey Hagen	" " " " "
Gaynor Longbrake	Aberdeen Area I.H.S.
Steven Haberfeld	First Nations Financial Project
Ted Means	Brotherhood Community Health Board
Warren Means	Brotherhood Community Health Center
Kathleen Kempter	Brotherhood Community Health Center
Darrell Shoemaker	Congressman Tim Johnson
Roger Condon	IHS - Rapid City
GORDON H. WILCOX	IHS ABERDEEN
[illegible]	IHS Aberdeen
Emma Hutcheson	IHS, Aberdeen
David Pourier	OST Councilman
Jerry Weston	OST Councilman
Gerald Big Crow	OST Councilman
Tom Welty	IHS - Aberdeen
Andrea L Smith	First Nations Financial Project
Carmen Weston	Brotherhood Comm. Health Board
Velma Kills Back	" " " "
Severt Young Bear	Brotherhood Comm - Chairman
Myrna Young Bear	Brotherhood Comm Health Bd. Member
Shirley Plume	OST Health Planner
[illegible]	[illegible]
Paul Iron Cloud	President Oglala Sioux Tribe

ATTACHMENT F

MEMORANDUM OF AGREEMENT
Developed 6/23/89

BROTHERHOOD COMMUNITY HEALTH CLINIC -
PINE RIDGE SERVICE UNIT, IHS, USPHS

PURPOSE

This document, initiated by Pine Ridge Service Unit (PRSU) and the Brotherhood Community Health Board, sets forth the conditions under which resources of the Indian Health Service will be utilized in the Brotherhood Community Health Center (BCHC) in the Porcupine District. The mutual goal of both organizations is to improve the health of all people in the Porcupine district and to insure coordination of ambulatory care with inpatient care. This agreement is based, in part, on Oglala Sioux Tribal Council resolution #86-24 dated 2/18/86.

PINE RIDGE SERVICE UNIT AGREES TO:

I. MEDICAL

A. Relocate to the Brotherhood facility those programs and professional services currently provided by IHS in the Porcupine District. These programs and services shall be maintained at no less than their current level as follows:

1. one day general clinic per week provided by a nurse practitioner, physician assistant, or physician
2. one midwife clinic per month
3. one immunization clinic per month provided by a public health nurse or nurse practitioner.

The following services will be provided:

1. Preventive services, including immunizations, well child care, prenatal care, and family planning services.
2. Care of chronic diseases including diabetes, hypertension, etc.
3. Treatment of acute illnesses and injuries that can be handled appropriately or triaged to a facility where definitive care can be provided.

B. Relocate existing medical equipment to the Brotherhood Community Health center facility to complement service delivery.

C. Complete the aforestated transfer of services and relocation of equipment so as to be fully operational no later than July 10, 1989. These services will be provided according to the monthly schedule from the PRSU.

D. Assist in the installation and calibration of any additional medical equipment obtained for the Brotherhood clinic. PRSU will schedule these services.

E. Provide consumable clinic and pharmaceutical supplies that are utilized by IHS professionals.

II. DENTAL

A. Relocate to the Brotherhood facility those professional dental programs and services currently provided by IHS in the Porcupine District. These programs and services shall be maintained at no less than their current level of two days per week.

The current level of dental services consist of:

Level I - Emergency care
Level II - Primary care
Level III - Secondary care

Higher levels of care will be provided dependent on availability of personnel and resources.

B. Maintain and repair, as needed, any IHS equipment utilized in the delivery of dental services in the Brotherhood facility.

C. Begin to provide IHS dental services at the Brotherhood clinic no later than August 14, 1989, contingent on:

(1) required equipment and instruments being available and installed (shown in Appendix A).
(2) equipment has been properly approved and calibrated by IHS bio-medical personnel.

III. MEDICAL RECORDS

A. Provide access to and use of IHS field clinic medical records to Brotherhood Health Center staff qualified in medical records confidentiality procedures.

B. Provide medical records training to Brotherhood staff.

C. Provide security storage for IHS medical records in locked filing cabinets.

D. Allow BCHC medical and medical redords staff to make photostatic copies of records of individuals who have signed release of information forms.

AUTHORITIES

A. Continue to operate and maintain full authority over IHS medical and dental programs and services once these are relocated in the Brotherhood facility.

B. Provide program and personnel supervision in accordance with IHS standards of care, policies and regulations.

C. Give full consideration to the Brotherhood Community Health Board's program initiatives and priorities. Prior to implementation of any changes in the scope or range of established services, there shall be formal consultation between IHS and the Brotherhood Board of Directors.

D. Those Medicare and Medicaid reimbursement funds generated by IHS activities conducted in the Brotherhood facility will be used to enhance services and programs locally as specified in an approved M&M plan jointly developed by IHS and BCHB.

E. Serve only IHS beneficiaries unless it is a medical emergency.

V. ADDITIONAL EQUIPMENT

A. Assist the Brotherhood Community Health Board to identify and obtain use of needed medical and dental equipment through the Federal government's surplus and excess property programs.

VI. ADDITIONAL RESOURCES

A. Continue to work with the Brotherhood Board to mobilize additional financial and professional medical and dental resources for program enhancement in the Porcupine community and Service Area.

BROTHERHOOD COMMUNITY HEALTH CENTER BOARD AGREES TO:

I. Provide appropriate space, rent free, for the provision of medical and dental programs and services. Charges for maintenance, housekeeping and utilities will be based on square footage utilization and time, as a percentage of total costs.

II. Provide reasonable care and security of IHS equipment located within the Brotherhood facility.

III. Maintain accepted standards of confidentiality in using medical records that are the property of the IHS field clinic program.

IV. Work with the local school systems to coordinate transportation needed by children to access dental services at the Brotherhood clinic.

TIME FRAME OF THIS AGREEMENT

This agreement will remain in effect for only as long as both parties continue to agree. There must be 90 days written notice given if a party wishes to withdraw from the agreement. Should there be a dissolution of this agreement, the PRSU medical records and equipment will be retained by PRSU.

This agreement will be formally reviewed every three months by the Executive Director of BCHC and PRSU Service Unit Direcotr on the first Monday of January, April, July and October so that coordination of services will be facilitated and problems resolved before they become major conflicts. These meetings will be held at 1 PM in the Brotherhood clinic unless other arrangements are made. Other meetings will be held as needed to resolve problems in the day to day operation of the clinic and coordination of services with IHS.

Signed,

Date

HOMER KILLS BACK
CHAIRMAN, BOARD OF DIRECTORS
BROTHERHOOD COMMUNITY HEALTH CLINIC
P.O. Box 99
Porcupine, SD 57772

Date

GEORGE HOWELL
PINE RIDGE SERVICE UNIT DIRECTOR
INDIAN HEALTH SERVICE, USPHS
Pine Ridge, SD 57770

Date

TERRANCE W. SLOAN, M.D.
ABERDEEN AREA INDIAN HEALTH
SERVICE DIRECTOR, USPHS
Aberdeen, SD 57401

Date

PAUL IRON CLOUD
TRIBAL COUNCIL PRESIDENT
OGLALA SIOUX TRIBE
Pine Ridge, SD 57770

ATTACHMENT G

FIRST NATIONS FINANCIAL PROJECT
69 Kelley Road • Falmouth, Virginia 22405 • (703) 371-5615

TO: Paul Iron Cloud, OST President
George Howell, SUD PRSU
Dr. Terrance Sloan, MD Area Director
Rich Gordon, Representing, Senator Daschle
Darrel Shomaker, Representing, Congressman Johnson
Warren Means, BCHB Project Consultant
Homer Kills Back, Chairman BCHB
Dr. Thomas Welty, Epidemiologist, Sioux-San Hospital
Steve Haberfeld, First Nations Financial Project

FROM: Andrea Smith, First Nations Financial Project

DATE: March 12, 1990

SUBJECT: Brotherhood Community Health Clinic Scheduled March 16, 1990 meeting

Each person listed above has been contacted by phone and has been notified of the upcoming meeting to be held at the Black Hills Training Center, Third Floor, Sioux-San Hospital at 10:00 am. In addition, each person has made a verbal commitment to attend or send an authorized representative. This memo is to serve as confirmation of the meeting and your acknowledgement of attendance.

The purpose of this meeting is to discuss the Memorandum of Agreement developed on June 23, 1989 between the IHS and the Brotherhood Community Health Board. Specific concerns include the provision in which IHS agreed to provide coverage of the overhead costs associated with the maintenance, housekeeping and utilities of the field health clinics. It appears there is confusion as to how this should be implemented.

In addition, we invite input and suggestions to strengthen the current Memorandum of Agreement and the future relationship between the Brotherhood Community Health Board and the IHS. It is anticipated that these efforts will lead toward the modeling of national legislative policy to benefit Indian clinics across the country.

It is hoped that if IHS requires additional technical expertise regarding implementation of the Memorandum of Agreement, the department specialists necessary for this will also be present.

The meeting will be facilitated by First Nations Financial Project. We are confident that this will be a successful and productive meeting and look forward to your participation.

1291a

SIGN UP LIST

TRAINING COURSE: AAO & BROTHERHOOD MEETING DATE: Friday - 3/16/90

DATE **NAME & TITLE** **ADDRESS**

1. 3-16-90 Irma Bear Stops OST Health Board Wanblee S.D
2. 3-16-90 Esther [illegible] - OST Health Services - Manderson, SD
3. 3-16-90 Arta Carlow OST Health Board Pine Ridge S.D.
4. 3-16-90 Beatrice Weasel Bear O.S.T. Health Ed. P.R. S.D.
5. 3-16-90 [illegible] First Nations Financial Project
6. 3/16/90 Gerald Sherman BCHB, Martin, SD
7. 3/16/90 Steven Haberfeld First Nations
8. 3/16/90 Darrell Shoemaker Congressman Tim Johnson Box 1098 Rapid City 57709
9. 3/16/90 Darryl Drapeaux IHS Property Mgmt. Aberdeen, SD
10. 3/16/90 ALCATIE S. CLIFFORD IHS Contracting, ABERDEEN, SD
11. 3-16-90 Leonard L. FINGER IHS Pine Ridge S.U. Pine Ridge SD
12. 3-16-90 Tom Welty IHS Med Epi Rapid City, SD
13. 3-16-90 Ronnie Song IHS Gerontology/Rehab - Rapid City
14. 3-16-90 David [illegible] BCHB Porcupine S.D.
15. 3-16-90 Homer Kills Back Chairman BH.C.H.B Box 278 Porcupine, S.D.
16. [illegible] Long [illegible] IHS
17.
18.
19.
20.
21.
22.
23.
24.
25.

Name - mailing address - [illegible] II

HOBBS, STRAUS, DEAN & WILDER
LAW OFFICES
1819 H STREET, N.W., SUITE 800
WASHINGTON, D.C. 20006
(202) 783-5100
TELECOPIER (202) 296-8834

CAROL L. BARBERO (DC)
S. BOBO DEAN (DC, NY)
HAROLD M. GROSS (DC, CA, OR)
CHARLES A. HOBBS (DC)
FRANCES L. HORN (DC)
MATTHEW S. JAFFE (DC, MD)
MARSHA KOSTURA (DC, PA)
JOSEPH J. B. RYAN (DC, TX)
JUDITH A. SHAPIRO (DC)
CHRISTOPHER T. STEARNS (NJ)
JERRY C. STRAUS (DC)
DEAN B. SUAGEE (DC)
HANS WALKER, JR. (DC, ND)
LEROY W. WILDER (OR, DC, CA)

MICHAEL P. GROSS (NM, AZ)
KENNETH F. TWOROGER (DC, FL)
ROBERT H. WAGSTAFF (AK, KS)
OF COUNSEL

KAREN J. FUNK
GOVERNMENTAL AFFAIRS COORDINATOR
(NOT ADMITTED TO ANY BAR)

PORTLAND OFFICE:
0225 S.W. MONTGOMERY STREET, #6
PORTLAND, OREGON 97201
(503) 242-0708

NEW MEXICO AFFILIATE:
ROTH, VAN AMBERG, GROSS & ROGERS
P.O. BOX 1447
SANTA FE, NEW MEXICO 87501
(505) 988-8979 AND 983-7319

FLORIDA AFFILIATE:
TWOROGER & ASSOCIATES
P.O. BOX 11808
FORT LAUDERDALE, FLORIDA 33339
(305) 566-8990

ALASKA AFFILIATE:
WAGSTAFF, POPE & CLOCKSIN
912 WEST SIXTH AVENUE
ANCHORAGE, ALASKA 99501
(907) 277-8611

April 18, 1990

The Honorable John McCain
United States Senate
Washington, D.C. 20510

Attention: Mr. David McIntyre

Re: Metlakatla Indian Community Health Facility Needs

Dear Senator McCain:

We are submitting this letter on behalf of our client, the Metlakatla Indian Community, for inclusion in the March 22nd hearing record of the Senate Select Committee on Indian Affairs on facility needs for Alaska Native and Indian health programs. The Metlakatla Indian Community, located on the Annette Islands Reserve in Alaska, is an Indian Tribe organized under the Indian Reorganization Act. The Community provides health services on its reservation and operates an out-patient clinic under the Indian Self-Determination Act.

It is a scandal that the IHS priority construction list does not include plans for the construction of a replacement out-patient clinic for the Metlaklatla Indian Community. Despite the fact that the IHS Area Office has ranked the Metlakalta Clinic first on their list for replacement and has urged that IHS take immediate action, the Community has been unable to get on the national IHS priority construction list. Attached is the May 19, 1989 correspondence from the Area Director to IHS Headquarters asking that special consideration be given to placing construction of an outpatient clinic at Metlakalta on the Phase I priority list. However, IHS Headquarters denied this request on the grounds that the priority list is "frozen" pending review of the system by Congress.

The physical condition of the Community's clinic makes it imperative that a replacement clinic be built. A February 1988 environmental health survey of the existing clinic and a March 1989 review conducted by the State of Alaska pursuant to Health Care Financing Administration requirements documented severe design and operational problems with the clinic. The purpose of the March, 1989 review was to determine if the clinic could be certified to participate in the Medicare/Medicaid billing program (something which would be of great benefit to our clients and to the facility), but the clinic was turned down for the program based on the many facility deficiencies.

Some of the documented problems with the out-patient clinic at Metlaklata include: limitation on the number of exits, the narrowness of corridors, the inadequacy of a fire prevention plan, deficiencies in the electrical and sanitation systems, dry-rot in the structure and a variety of other serious deficiencies.

Exacerbating the problem with the current facility is the geographic location of the Annette Islands Reserve. The Metlakatla Indian Community is on an island which has no hospital and has, as described above, a totally inadequate out-patient clinic. The weather in southeastern Alaska is such that people are often cut off for days or weeks from outside health service resources. There is no opportunity, as exists in some parts of the country, for the utilization of an out-patient clinic of a neighboring community. The physical condition of the Community's clinic and its dependence on a local facility makes its imperative that they be placed on the IHS priority list for construction.

We request that the Senate Select Committee Indian Affairs make it clear to IHS that the initiative to find alternative ways of financing and utilizing facilities is not an excuse for IHS to ignore urgent health and safety deficiencies in facilities serving Indian and Alaska Native people, including the "freezing" of its priority construction system. We also request that increased funds be appropriated for new construction for facilities. We appreciate the work of the Senate Select Committee on Indian Affairs in bringing to public attention, through the recent Library of Congress report, the low levels of federal spending on programs designed to benefit Native people, and hope that this heightened awareness will result in funding for facilities for Indian health programs.

Finally, we urge that the authority to lease provided in the 1988 Amendments to the Indian Health Care Improvement Act be implemented. Section 704 of the Indian Health Care

Improvement Act provides that IHS facility leasing arrangements with tribes and tribal organizations are authorized "notwithstanding any other provision of the law", but IHS has said that it can enter into an initial lease agreement only when the facility has been placed on the priority system and with the approval of the Congressional appropriations committees. We ask your assistance in ensuring that the FY1991 Interior and Related Agencies Appropriations law does not contain, as does the FY1990 appropriations law, language directing IHS to obtain an advance provision in appropriations law before entering into an initial leasing arrangement of a facility. There are a number of tribes who could arrange for credit for facility construction if they were assured of a IHS leasing agreement.

Thank you for your attention to the need of the Metlakalta Indian Community for a replacement out-patient clinic. Please let us know if we can provide further information.

Sincerely,

HOBBS, STRAUS, DEAN & WILDER

By: S. Bobo Dean

Enclosure

cc: Honorable Ted A. Littlefield, Sr.
Mr. Greg Argel
Mr. Ray Herrera
Honorable Ted Stevens
✓Honorable Frank Murkowski
Honorable Don Young
Honorable Daniel Inouye

OCT [illegible] '89 09:34 MIC METLAKATLA AK

UNITED STATES GOVERNMENT

memorandum

DATE: May 19, 1989

REPLY TO ATTN OF: Director
Alaska Area Native Health Service

Refer To: A-D (A-PLS)

SUBJECT: Request for Special Consideration of Annette Island Indian
Health Center in the IHS Facilities Construction Priority System

TO: Bill F. Pearson, Associate Director
Office of Environmental Health & Engineering, Rockville

The Alaska Area is requesting a special consideration of the Annette Island Indian Health Center in this year's application of phase I of the facilities priority system. We have attached a copy of our initial application in November, 1988. In following the data form, the final priority score achieved was only 128, largely driven by the small size of the Annette Island user population (1643) and its corresponding workload (7,341 PCPV's).

In our Health Facilities Master Plan we listed the Annette Island Indian Health Center as our number one facility for replacement during the period of the plan. In requesting this special consideration we have outlined two major reasons for our doing so, 1) the present condition of the physical plant and 2) the relative isolation of the service population from any outpatient acute care services, either direct or contract, especially during winter months.

Condition of Present Facility

The Annette Island Indian Health Center, which was constructed [illegible] is plagued by a variety of structural and functional [illegible] deficiencies. The present health center is outdated and in [illegible] immediate replacement. It is located in a [illegible],400 square foot wood frame structure. A 1985 deep look survey of the facility revealed [illegible] problems with the structure both inside and outside. The results [illegible] survey are attached. The physical plant does not meet the [illegible] code requirements of the Joint Commission of Accreditation of Healthcare Organizations. A more recent deep look survey was conducted on March 25, 1988, and is also attached. Finally, a comprehensive Environmental Health Survey was conducted at the health center on January 5, 1988. In that survey several design and operational deficiencies were found which could adversely affect the health and safety of patients and staff at the health center. The results of this recent survey are also attached.

The total cost to correct facility deficiencies is estimated to exceed $600,000. Considering this cost and the age and types of problems with the existing facility, it would be more cost effective to replace the facility rather than trying to remodel the present one. The total replacement cost based on 3,589 GSF @ $214.41 per square foot is $769,51

OPTIONAL FORM NO
(REV. 1-80)
GSA FPMR (41 CFR) 101-
5010-114
☆ U.S. GPO: 1986

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Relative Isolation of the Service Population

The Annette Island Indian Reservation is located in the southernmost portion of the Alaska "panhandle", approximately 680 air miles north of Seattle and 900 air miles south of Anchorage. Annette Island has rugged, mountainous topography which inhibits transportation, communications, and development. The island is characterized by a number of large lakes which occupy former glacial valleys. Population is concentrated in the town of Metlakatla, located on the northern tip of the peninsula, and in Annette, an old FAA-Coast Guard complex, located seven miles to the south. The remaining portion of the island is relatively uninhabited and activity is limited to seasonal logging operations, fishing and recreation. Transportation to and from the island is provided by commerical air and State ferry system. Air service, although widely used within the region, is unreliable during periods of stormy weather. During winter many of the ferry trips to Ketchikan, the closet source of additional health care, are cancelled due to weather conditions. Trips and ferry service are suspended one to two months each year for vessel maintenance.

The Annette Island Indian Health Center is the only source of acute outpatient care for the residents of the town of Metlakatla and the Annette Island Indian Reservation. The closest source of additional acute care is in Ketchikan which can be reached only by ferry or air.

For the reasons given above the Alaska Area is requesting special consideration of the Annette Island Indian Health Center in phase I of this year's facility priority system. I would appreciate your giving special attention to this request.

G. H. Ivey

Attachments

cc: Tom Gallegos

06 '89 09:35 MIC METLAKATLA H P.4

OUTPATIENT

IHS FACILITIES CONSTRUCTION PRIORITY SYSTEM

DATA FORM

Proposed Site METLAKATLA

Service Unit ANNETTE ISLAND

Outpatient Care Service/Eligible Population (1987) 1643

Date 11/88

IHS Area ALASKA

1. WORKLOAD: On lines 1a, 1b, 1c, and 1d enter the primary care provider visits (PCPV) as prompted in the text on the left. Add these to obtain the total PCPV expected at the facility.

a. On line 1a, enter the PCPV direct to the facility from within the service area. 7341 1a

b. On line 1b, enter the PCPV direct to this facility from outside the service area. 461 1b

c. On line 1c, enter the PCPV direct to nearby IHS facilities from the facility's service area. 754 1c

d. On line 1d, enter 25% of the contract care workload. 73 1d

e. Add lines 1a, 1b, 1c, and 1d and enter the result on line 1e. (1e = 1a + 1b + 1c + 1d) 8429 1e

f. On line 1f, enter the total PCPV, regardless of where or how care was provided, for the residents of the facility's service area during the latest complete fiscal year. 8387 1f

2. PRIMARY CARE PROVIDER VISIT RATE

a. (PCPV rate) On line 2a, enter the user population (patient registration system based) for the service area 1643 2a

b. Calculate the PCPV rate by dividing line 1f by line 2a. Enter the result on line 2b. (2b = 1f / 2a) 5.1 2b

3. ADJUSTED PCPV Compare line 2b with the IHS upper utilization rate (6.1) and the IHS lower utilization rate (3.0). Determine which statement (I, II, or III) below applies. Follow the instructions in the statement.

3-I a. If the PCPV Rate (line 2b) is less than IHS the lower limit (3.0), subtract line 2b from the IHS lower limit utilization rate. Enter the result on line 3a. (IHS lower utilization rate - 2b) 3a

b. Multiply line 3a times line 2a. Enter the result on line 3b. (3a X 2a) 3b

Add line 3b and line 1e and enter on line 3e below. Read the instructions at 3e below. (3e = 3b + 1e)

3-II If the PCPV Rate (line 2b) is greater than the IHS lower limit (3.0) and less than the IHS upper limit (6.1), copy line 1e to line 3e below. Read the instructions at 3e below. (3e = 1e)

3-III c. If the PCPV Rate (line 2b) is the greater than the upper limit (6.1), subtract the upper limit from line 2b. Enter the result on line 3c. (3c = 2b - IHS upper limit) 3c

d. Multiply line 2a times line 3c and enter the result on line 3d. (2a X 3c) 3d

Subtract line 3d from line 1e. Enter the result on line 3e. (3e = 1e - 3d)

e. Enter the result from 3-I, 3-II, or 3-III, as appropriate, on line 3e. Place only one of the results on line 3e. Line 3e is the Adjusted PCPV for the proposed facility. Go to item 4. 3629 3e

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[illegible] score. Enter the [illegible]

5. [illegible] To determine the space required facility, multiply the adjusted PCPV times 0.3 square feet and add 1,000.

a. [illegible]sume that a basic outpatient facility requires 1,000 square feet.

1,000
5a

b. Assume that an outpatient facility requires 0.3 additional square feet for each primary care provider visit.

0.3
5b

c. Multiply line 3a (adjusted PCPV) times line 5b. Enter the result on line 5c. (5c = 3a X 5b)

2589
5c

d. Add line 5a to line 5c to determine the Required Space for this facility. (5d = 5a + 5c)

3589
5d

6. a. On line 6a enter the building gross square feet. This is available from the Area Real Property Unit Managers.

2400
6a

b. Multiply line 6a times 0.5. (6b = 6a X 0.5)

1200
6b

7. FACILITY EVALUATION SCORE - Complete section 7 using the latest Facilities Engineering Deficiency System (FEDS). The OFM will verify the information. This information will be used to calculate the Existing Space Adjustment Factor (ESAF)

a. On line 7a, enter the cost to correct legal and code deficiencies. FEDS code numbers 2, 3, 4, 7, and 8.

7a

b. On line 7b, enter the cost to correct FEDS deficiencies. FEDS code numbers 11, 12, 13, 14, and 15.

208,600
7b

c. On line 7c, enter the cost to correct deficiencies noted by Medicare, Medicaid, and JCAH surveys.

428,000
7c

d. Add lines 7a, 7b, and 7c to obtain the total cost to repair and enter on line 7d. (7d = 7a + 7b + 7c)

636,300
7d

8. Calculate the cost per square foot to repair the facility by dividing the total cost to repair by the building gross square feet of the existing facility.

a. Divide line 7d by line 6b to determine the cost per square foot to repair the facility. Enter the result on line 8a. (8a = 7d / 6b)

636,300/1200 =

530.25
8a

9. If the proposed facility will replace an existing facility, determine the Existing Space Adjustment Factor (ESAF) by dividing the cost per square foot to repair an existing facility by the Hanscomb cost per square foot to replace it with a new facility. If the proposed facility is a new facility and does not replace an existing facility, the ESAF is 1, and 1 should be entered on line 9b.

a. Enter the Hanscomb cost per square foot to replace the facility on line 9a. The Hanscomb cost includes the base facility cost from Table 1 on pages A-5 to A-33 of the IHS Budget Cost Estimating System manual.

214.41
9a

b. If there is an existing facility at the location, divide line 8a (Cost to Repair) by line 9a (Cost to Replace) and enter the result on line 9b.

530.25/214.41

2.47
9b

If there is no existing facility, enter 1 on line 9b.

The ESAF is the value entered on line 9b. (9b = 8a / 9a) or (9b = 1)

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✓ [illegible] the formulas below as instructed. These formulas calculate [illegible] adjustment to the Base Demand Score. Multiplying the existing space adj[illegible] times the Base Demand Score generates a priority score which accounts for workload demand, facility size, and cond[illegible] the facility.

10 [illegible] ine the Priority Score as indicated below.

a. M[illegible]y line 6b (Required Space) times line 9b (CSAF) and enter the result on line 10a. (10a = 6b x 9b) 1200(2.47) =

2964
10a

b. Subtract line 10a from line 6b (Required Space) and enter the amount on the line to the right. (10b = 6b - 10a) 1200 - 2964 = -1764

-1764
10b

c. Subtract line 10b from line line 5d (Required Space) and enter the result on 10c. (10c = 5d - 10b) 3539 - (-1764) =

5353
10c

d. Divide line 10c by line 5d. This generates the Existing Space Adjustment to the Base Demand Score. Enter the result on line 10d. (10c / 5d) 5353/3589

1.49
10d

e. Multiply line 4a (Base Demand Score) times line 10d (Existing Space Adjustment) to get the Priority Score and enter it on the line to the right. (SCORE = 4a X 10d)

86(1.49)

128
PRIORITY SCORE

Replacement Cost:

3589 GSF ($214.41) = $769,517 (1989)

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SCHEMATIC DESIGN
FOR
NORTON SOUND HEALTH CORPORATION
HOSPITAL

NOME, ALASKA

APRIL 21,1989

PREPARED BY:

LIVINGSTON SLONE, INC.

Architects, Engineers & Planners

Livingston Slone, Inc.
3900 Arctic Blvd., Suite 301
Anchorage, Alaska 99503
(907) 562-2058

NSHC08/100

I. INTRODUCTION

This document is a presentation of the Schematic Design for Phase II construction of a two phase Masterplan to remodel the existing Norton Sound Regional Hospital (NSRH) to correct programmatic deficiencies and add space to the hospital.

Norton Sound Regional Hospital is operated by Norton Sound Health Corporation (NSHC). NSHC and the Regional Hospital serve the Bering Straits Region which consists of 25,000 square miles of subarctic geography, fifteen isolated native villages, and the hub city of Nome.

The hospital began as an effort by the United Methodist Church in the late 1940s to provide acute care to these remote regions. Norton Sound Health Corporation was formed in 1970 under a federally funded demonstration project to show the viability of consumer-directed health care delivery and to develop indigenous health care providers. By 1972, it had extended medical outreach by training Community Health Aides and assisted with construction of clinics in each of the fifteen villages. In 1977, NSHC purchased the existing private non-profit hospital and expanded the facility in 1978.

In 1986, a Facilities Masterplan and Facilities Space Program was prepared by Livingston Slone, Inc. for NSHC. The purpose of the Facilities Masterplan was to assess the existing facilities and provide recommendations for optimizing continued use and future development. The immediate goal of the Facilities Masterplan was to identify those functions most in need of upgrading and expansion. These identified functions make up the scope of work for Phase II construction.

II. SCOPE OF PROJECT

Phase II construction of the Norton Sound Regional Hospital will be designed following conventional A/E procedures from program and schematic design through production of construction documents and construction administration. The Architect has worked closely with Norton Sound Health Corporation to design an efficient and pleasing facility which provides for the following departments: Acute Care Nursing, Nursery, Delivery/Surgery, Laboratory/Pathology, Radiology, Emergency Department, Outpatient Department, Physical Therapy, Respiratory Therapy, Health Records, Employee Facilities, Consultation/Training, Public Facilities, Central Sterile and Reprocessing, Central Stores, Dietetics, Housekeeping and Linen, Maintenance, and Building Services. Phase III, which consists of Dental Clinic, Eye Clinic, Pharmacy, Audiology and Administrative Services, is not included as part of this contract, but is crucial to the ultimate utilization of Phase II improvements.

Phase I construction was a skilled nursing care addition constructed in 1987/88.

III. DESIGN ANALYSIS

GENERAL

The Schematic Design represents the present stage of planning which has been generated from the Facilities Masterplan, the Facilities Space Program, and close interaction between the Architect and Norton Sound Health Corporation. Refinements of the design will still evolve and be incorporated into later phases of the design as communications continue among those involved.

SITE FACTORS

The existing hospital is conveniently located on the northern edge of town in a quiet area. The existing hospital is situated on an entire city block bounded by streets on all sides: Sixth Avenue to the north; Fifth Avenue to the south; Division Street to the east; and West B Street to the west.

The hospital corporation owns three lots to the north across Sixth Avenue. The Central Warehouse is situated on them. The recently completed Community Health Services building is located on two lots to the east across Division Street. In addition, the Emergency Services Building sits on a lot on West B Street between Fourth and Fifth Avenues. This, too, is owned by the hospital. Rented space for additional Community Health Services functions is located on Division Street in the Sitnausuak Building which is a block south of the hospital site.

EXISTING BUILDING FACTORS

The current Norton Sound Regional Hospital consists of two very different buildings connected by an enclosed ramped walkway. The original building was constructed in 1948, and has serious building code violations. It does not meet minimum hospital standards and health code requirements, and has additional problems as well. Since it contains mostly office and support space, the older structure has been operating under a separate building code classification.

Numerous renovations and upgrades of the 1948 building have occurred over the years to accommodate newer codes and programmatic changes. The kitchen/laundry/dishwash spaces in the basement of the 1948 building have been upgraded to meet minimum State and local health and building codes on an interim basis (5 year life expectancy). This building has met its functional life expectancy and is due for replacement (a poor general condition, limited floor to floor dimension, and foundation settlement precludes any serious long term consideration of this building).

The 1978 addition essentially meets building code requirements, but has severe functional deficiencies: the laboratory is in critical need of more space and improved ventilation, and there are no labor rooms and pediatric rooms. The building's construction type is steel and wood frame on a wood piling foundation.

In addition to the two main buildings, there are two connected boiler houses located to the north of the 1948 building. They supply heat and other utilities to the complex. These boiler houses are pre-engineered metal buildings with limited life remaining.

Recently, an Eldercare wing (Phase I) has been added to the 1978 building at the southwest corner of the building site. The Eldercare consists of seven, two-bed patient rooms, one single bed patient room, a multi-purpose room, a dining room, and support services. The buildings construction type is steel and wood frame on a steel piling foundation.

IV. CONSTRUCTION RATIONALE

GENERAL

Phase II addresses the most critical short range program needs as well as functional deficiencies in the areas of circulation, entrance, egress, and parking. Because the functional operation of almost every department within the hospital is crucial to the entire operations of the facility, Phase II will need to be sequenced in three stages in order to provide continuous service during construction. These stages are referenced as Phase IIa, IIb, and IIc in this text and the accompanying drawings.

CONSTRUCTION SEQUENCING

In Phase IIa, a new dietetics service, housekeeping and linen, consulting/training, and employee facilities will be constructed, as well as a new mechanical room to serve the entire facility (existing and proposed). This will be an addition to the northeast corner of the 1978 building and will require the demolition of a small portion of the east wing of the 1948 building. The portion to be demolished currently houses some housekeeping, maintenance, and accounting space that will require temporary relocation. The existing kitchen and laundry will continue functioning in their present location in the basement of the 1948 building until Phase IIa is completed. At that time, when both the kitchen and laundry have moved into their new spaces, the remainder of the east wing of the 1948 building will be demolished as well as the boiler buildings. This will require temporary relocation of some administrative and central stores functions.

Phase IIb will see the construction of a major east/west corridor with well-defined public entrances. This corridor will function much like a shopping mall with hospital departments requiring direct public access facing the corridor. The "mall" will be architecturally emphasized to distinguish it from less important corridors. It will be situated so as to provide the possibility of a future direct connection east to the Community Health

Services (CHS) building and additional parcels of available land directly to the east of the hospital that may be required for future Norton Sound Health Corporation expansion. People entering from either end of this mall will readily locate either the public facilities reception desk or the reception for the direct service department they need. Patient access will be improved and circulation minimized.

Phase IIb will also include new space for Health Records, Laboratory/Pathology, Central Stores, Maintenance, and Building Services. About one half of the 1948 building will remain after the completion of Phase IIb. The Pharmacy will be temporarily relocated into the area formerly occupied by the Dietetics cafeteria and related storage. Eye Clinic and Dental Clinic will expand. Most remaining functions will continue in their approximate current location until the construction of Phase III.

The current functions of the 1978 building will remain largely within the existing building. Some will be relocated or remodeled to increase their efficiency. The Emergency Department and Radiology will expand on the south side of the building and two patient rooms will be added to the east. The Eldercare wing (Phase I) will remain unchanged. This remodeling and new construction effort will constitute Phase IIc. Outpatient services will move into the former waiting area. This will be adjacent to the Emergency Department and facilitate a close functional relationship between the two departments. Nursing, the delivery/surgery area, patient rooms, nursery and related support services will largely remain as they are. With the construction of the Eldercare wing, the day room formerly utilized for long term care will revert to acute care. The acute care nursing station will be relocated for improved visual access.

Respiratory Therapy and Physical Therapy will relocate and expand into space formerly occupied by Long Term Care and Health Records. Central Sterile will expand and be remodeled.

A major emphasis of Phase II will be to improve circulation within and access to the hospital. The present emergency entrance is often used as a main entrance because of its convenience and the lack of clarity of other building entrances. Phase II's new major entrance will de-emphasize the Emergency Department entrance to the building. This will recover currently wasted circulation space and make it available for more efficient health care delivery.

SUMMARY OF CONSTRUCTION SEQUENCING

Phase I:

1 Skilled nursing care addition (completed 1987/88).

Phase IIa:

1. Relocate affected departments and demolish east portion of 1948 building east wing.
2. Construct Dietetics, Housekeeping and Linen, Consultant/Training, Employee Facilities and Mechanical.
3. Move existing Kitchen, Housekeeping and Linen and Mechanical into new construction.

Phase IIb:

1. Relocate affected departments and demolish remainder of east wing of 1948 building.
2. Construct Public Facilities, Health Records, Laboratory/Pathology, Maintenance, Building Services, and Central Stores.
3. Move existing departments into new Phase II-b construction.

Phase IIc:

1. Construct new additions to 1978 building for Radiology, Emergency Department and two patient rooms.

2. Remodel 1978 building.

3. Move departments located outside 1978 building into remodeled portions (Respiratory Therapy, Physicians, etc.).

4. Refurbish remaining west wing of 1948 building to accommodate Dental Clinic, Eye Clinic, Pharmacy & Administrative services.

Phase III (future construction, not part of this design):

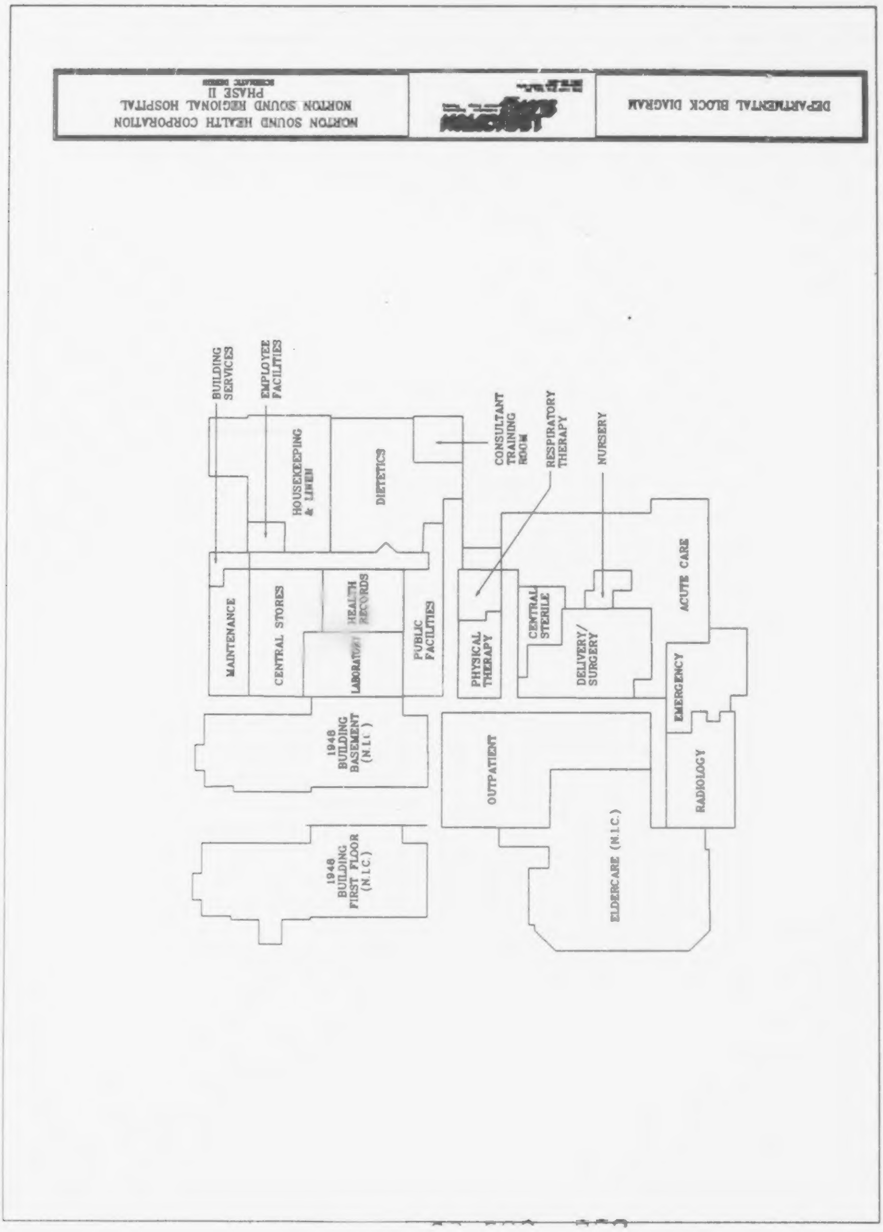
1. Construct new facility to replace west wing of 1948 building to house Dental Clinic, Eye Clinic, Pharmacy and Administrative Services.

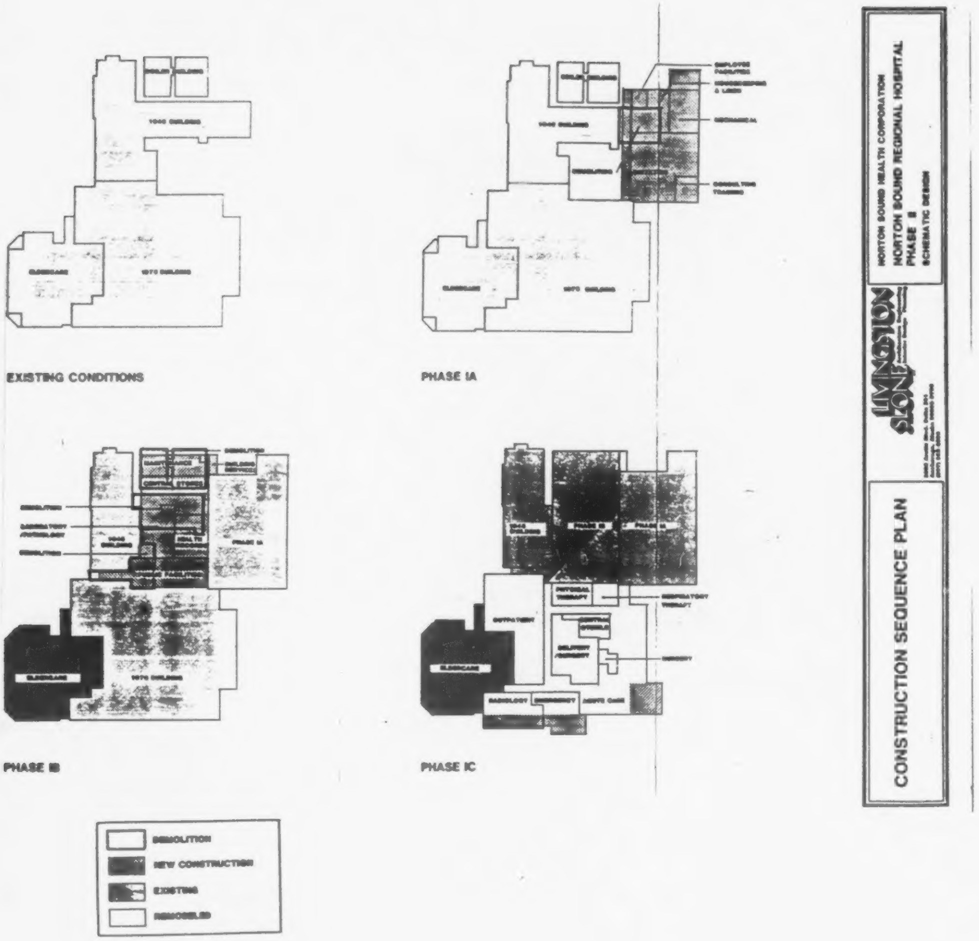
BUILDING EXTERIOR DESIGN

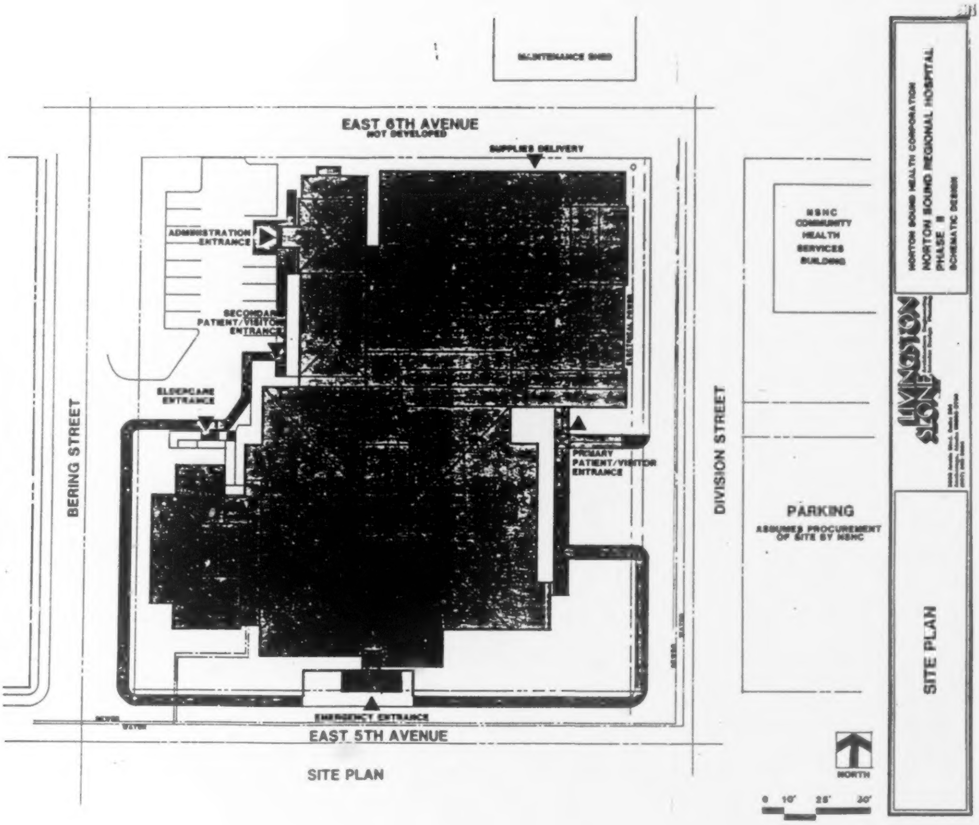
The scope of programmed Phase II additions and renovations is so extensive that it will have a major impact on the overall appearance of the Norton Sound Regional Hospital. This is viewed as an opportunity to upgrade the aesthetic appearance of the complex as well as the function. Since a majority of the 1948 building will be demolished in Phase II and the remainder in Phase III, minor effort will be made to relate it other than on a temporary functional basis. The design of the 1978 building, while utilitarian, does little to enhance the function and appeal of the hospital to the public and staff above a most basic level. The recently completed Eldercare (Phase I) relates to the 1978 building to which it is physically attached in terms of materials and overall color, yet asserts itself as having a unique identity, that of housing elderly people, through the use of unique forms accentuated with color.

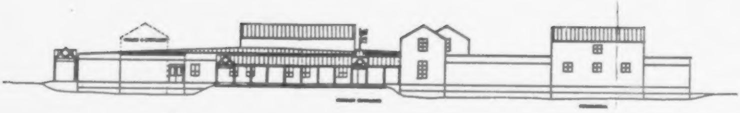
The continuation of the Eldercare approach serves as the basis of the Phase II exterior design rationale. Steeply pitched gabled roofs, similar to that over the Eldercare mechanical room, will allow similar functions to occur as required in Phase II, as well as emphasize important public spaces and entrances. These high spaces allow the introduction of natural light into otherwise enclosed interior spaces again as was done in the Eldercare.

Gabled roofs over walkways at the main Hospital entrance court and the Emergency entrance provide some protection from the natural elements, will clearly identify those important entrances and be pleasing to the eye. Careful use of the above mentioned design elements will recall images not unlike the best aspects of a typical Nome city block. The overall design attempts to create a scale that a person can relate to at a pedestrian level since a great deal of traffic to and from the hospital is by foot. In short, an effort will be made through form, scale and color to minimize the institutional quality of the current hospital and create an inviting, village like complex that will promote use of the services provided as well as an uplifting environment to encourage employee productivity.

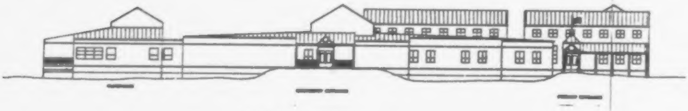

NORTON SOUND HEALTH CORPORATION
NORTON SOUND REGIONAL HOSPITAL
PHASE II
SCHEMATIC DESIGN
DEPARTMENTAL BLOCK DIAGRAM
BUILDING SERVICES
EMPLOYEE FACILITIES
HOUSEKEEPING & LINEN
DIETETICS
CONSULTANT TRAINING ROOM
RESPIRATORY THERAPY
NURSERY
MAINTENANCE
CENTRAL STORES
HEALTH RECORDS
LABORATORY
PUBLIC FACILITIES
PHYSICAL THERAPY
CENTRAL STERILE
DELIVERY/ SURGERY
ACUTE CARE
EMERGENCY
1948 BUILDING BASEMENT (N.I.C.)
OUTPATIENT
RADIOLOGY
1948 BUILDING FIRST FLOOR (N.I.C.)
ELDERCARE (N.I.C.)


EXISTING CONDITIONS
BOILER BUILDING
1946 BUILDING
ELDERCARE
1970 BUILDING
PHASE IA
EMPLOYEE FACILITIES
HOUSEKEEPING & LINEN
MECHANICAL
CONSULTING TRAINING
DEMOLITION
PHASE IB
DEMOLITION
LABORATORY /PATHOLOGY
PHASE IA
PHASE IC
OUTPATIENT
PHYSICAL THERAPY
RESPIRATORY THERAPY
CENTRAL SUPPLY
DELIVERY /SURGERY
RADIOLOGY
EMERGENCY
ACUTE CARE
DEMOLITION
NEW CONSTRUCTION
EXISTING
REMODELED
CONSTRUCTION SEQUENCE PLAN
LIVINGSTON SLONE
NORTON SOUND HEALTH CORPORATION
NORTON SOUND REGIONAL HOSPITAL
PHASE II
SCHEMATIC DESIGN

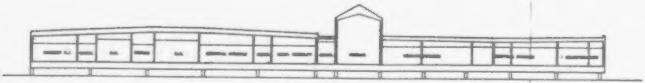

MAINTENANCE SHED
EAST 6TH AVENUE
NOT DEVELOPED
SUPPLIES DELIVERY
ADMINISTRATION ENTRANCE
SECONDARY PATIENT/VISITOR ENTRANCE
ELDERCARE ENTRANCE
PRIMARY PATIENT/VISITOR ENTRANCE
ELECTRICAL FEEDS
BERING STREET
DIVISION STREET
EMERGENCY ENTRANCE
EAST 5TH AVENUE
SITE PLAN
NSHC COMMUNITY HEALTH SERVICES BUILDING
PARKING
ASSUMES PROCUREMENT OF SITE BY NSHC
NORTH
0 10' 25' 30'
NORTON SOUND HEALTH CORPORATION
NORTON SOUND REGIONAL HOSPITAL
PHASE II
SCHEMATIC DESIGN
LIVINGSTON SLONE
SITE PLAN



EAST ELEVATION



SOUTH ELEVATION

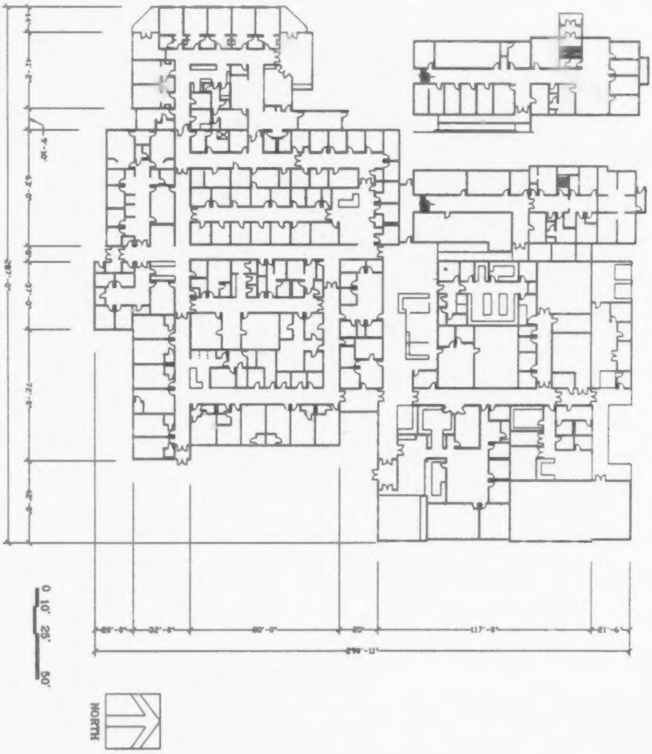


BUILDING SECTION

NORTON SOUND HEALTH CORPORATION
NORTON SOUND REGIONAL HOSPITAL
PHASE II
SCHEMATIC DESIGN

LIVINGSTON SLONE

BUILDING ELEVATIONS AND SECTION


41'-2"
9'-10"
63'-0"
37'-0"
72'-8"
42'-0"
287'-0"
28'-8"
32'-8"
80'-0"
20'
117'-8"
21'-6"
299'-11"
0 10' 25' 50'
NORTH

OVERALL FLOOR PLAN

NORTON SOUND HEALTH CORPORATION
NORTON SOUND REGIONAL HOSPITAL
PHASE II
SCHEMATIC DESIGN

VI. PHASE II PROGRAM AREA SUMMARY

GENERAL

The following Phase II program area summary has been generated by the following method. In 1985, a Services and Operations Plan, prepared by JoAnn Bernier, researched, documented and assessed each service offered by Norton Sound Health Corporation. Based on her findings, Ms. Bernier projected short and long term needs for staff and space. The Space Program, prepared by Bertis Rasco, AIA of SMP Architects, translated and projected these short and long range space needs into square footage required by each service. IHS planning criteria (HFPM Oct. '80) was used in new construction areas and where appropriate in renovated areas.

A Facilities Master Plan, prepared by Livingston Slone, was generated from the above mentioned documents. The purpose of this Facilities Master Plan was to assess the existing facilities and provide recommendations for optimizing continued use and future development. The immediate goal for the Facilities Master Plan was to identify a Phase II project which would identify those functions most in need of upgrading and expansion. Those Phase II areas are identified and summarized as follows.

DEPARTMENT SQUARE FOOTAGE SUMMARY

DEPARTMENT NAME	DEPARTMENT NET AREA (NSF)	DEPARTMENT FACTOR	DEPARTMENT GROSS AREA (DGSF)
Inpatient Services			
Acute Care Nursing	4,700	x 1.25 =	5,875
Nursery	370	x 1.45 =	537
Delivery/Surgery	2,185	x 1.55 =	3,387
TOTAL	7,255		9,799
Diagnostic Services			
Laboratory/Pathology	1,480	x 1.3 =	1,924
Radiology	1,385	x 1.45 =	2,008
TOTAL	2,865		3,932
Ambulatory Services			
Emergency Department	1,365	x 1.35 =	1,843
Outpatient Department	2,960	x 1.35 =	3,996
Physical Therapy	1,140	x 1.3 =	1,482
Respiratory Therapy	530	x 1.3 =	689
TOTAL	5,995		8,010
Administrative Services			
Health Records	1,760	x 1.2 =	2,112
Employee Facilities	264	x 1.15 =	304
Consultation/Training	560	x 1.15 =	644
Public Facilities	2,200	x 1.15 =	2,530
TOTAL	4,784		5,590

DEPARTMENT NAME	DEPARTMENT NET AREA (NSF)	DEPARTMENT FACTOR	DEPARTMENT GROSS AREA (DGSF)
Support Facilities			
Central Sterile & Reprocessing	730	x 1.15 =	840
Central Stores	1,870	x 1.1 =	2,057
Dietetics	2,870	x 1.2 =	3,444
Housekeeping & Linen	1,195	x 1.1 =	1,315
Maintenance	1,420	x 1.15 =	1,633
Building Services	160	x 1.1 =	176
TOTAL	8,245		9,465

Area Summary	Department Gross Area		Floor Gross Area
Inpatient Services	9,799	x 1.2 =	11,759
Diagnostic Services	3,932	x 1.2 =	4,718
Ambulatory Services	8,010	x 1.2 =	9,612
Administrative Services	5,590	x 1.2 =	6,700
Support Facilities	9,465	x 1.2 =	11,358
TOTAL FLOOR GROSS AREA			44,147
	Total Floor Gross Area		
Major Mechanical Space	44,147	~~x 0.08 =~~	3,532
BUILDING GROSS AREA (Total of Floor Gross & Major Mechanical Space)			47,679

NSHC08/120

VII. PHASE II DEPARTMENT PROGRAMS AND FLOOR PLANS

ACUTE CARE NURSING - MEDICAL/SURGICAL/PEDIATRICS/OBSTETRICS

The nursing unit is organized with the nurses station as the origin of care and treatment of the patient. It should be located for visual control of all normal entry/exit points to the unit and direct visual access to a number of patient rooms. The nurses station consists of a nurses charting and control area, a medication alcove, and a dictation booth. These areas operate as a unit. Located near the nurses station are the utility rooms, a nourishment station, staff lounge/lockers and toilets, and a treatment room.

The nursing staff operating from the nurses station provide for the prescribed and comfort needs of the patient. Nursing staff must be in constant contact with each patient. All beds are assumed to be served from one nurses' station.

Medications are prepared by the inpatient pharmacy in unit doses. They are delivered daily to the medication alcove on a Unit Dose Cart. Following instructions of the physician, nursing personnel dispense medication to the patient.

Patient meals are prepared and delivered to the nursing unit by Dietetics Services personnel. They make final preparation of the tray and deliver it to the patient from the nourishment kitchen. Ambulatory inpatients may go to the nursing units' dayroom or the cafeteria to receive their meals.

Many treatments are performed by doctors, nurses and/or therapists in the patient room. However, in some circumstances the patient will be taken to the exam and treatment room for special treatment or examination.

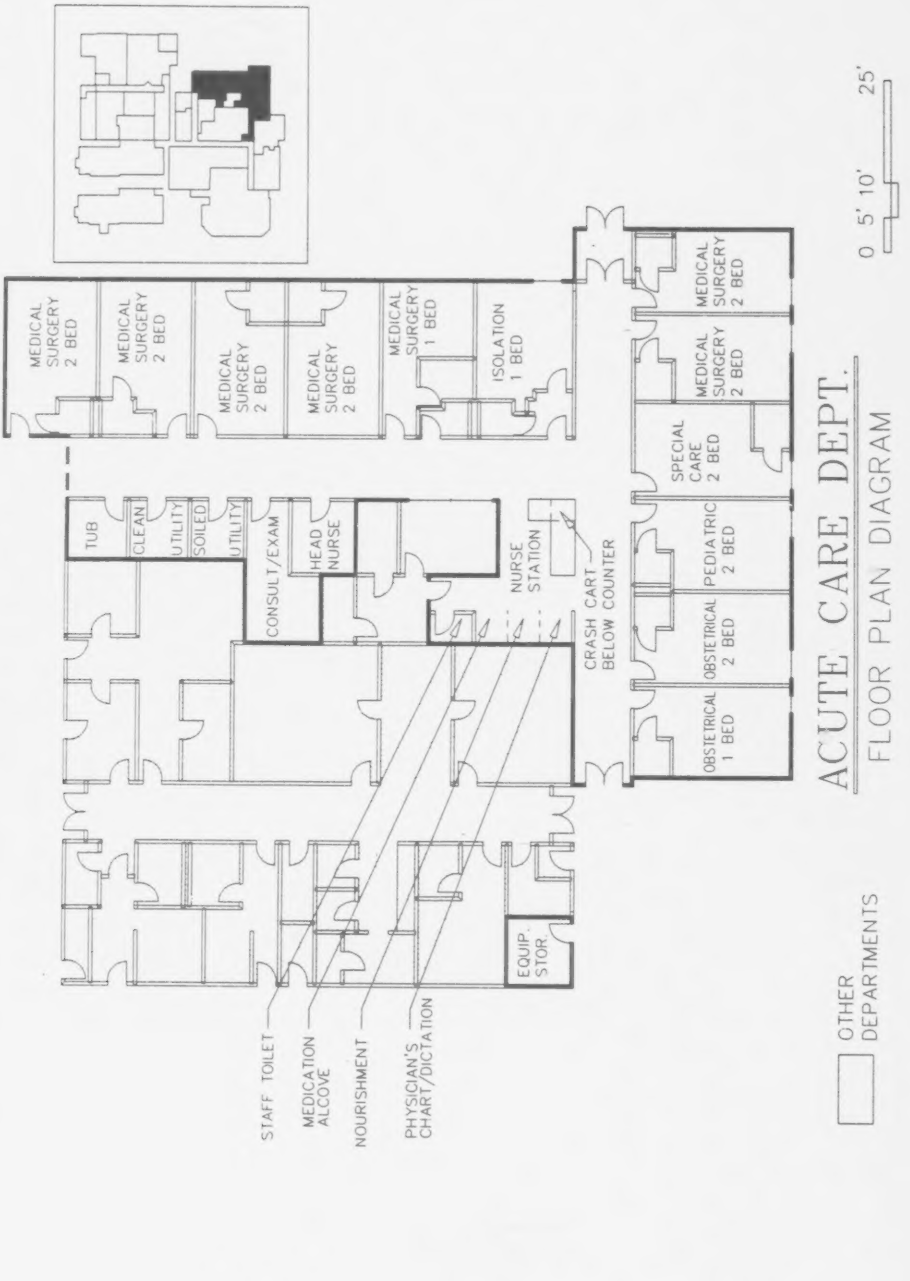
Medical and other supplies will be brought to the unit on either an exchange cart or in a 30-day bulk supply for holding in the clean utility room. Additional information is contained in Central Stores.

NSHC08/101

Total Facility Beds

	Rooms	Beds	Area SF	Total SF
Medical/Surgical				
One Bed Room	1	1	180	180
Isolation Room (General)	1	1	220	220
Two Bed Room	6	12	280	1680
Pediatric				
Two Bed Room	1	2	280	280
Obstetrical				
One Bed Birthing Room	1	1	280	280
Two Bed Room	1	2	280	280
Special Care				
Two Bed Room	1	2	220	220
TOTAL	12	21		3140

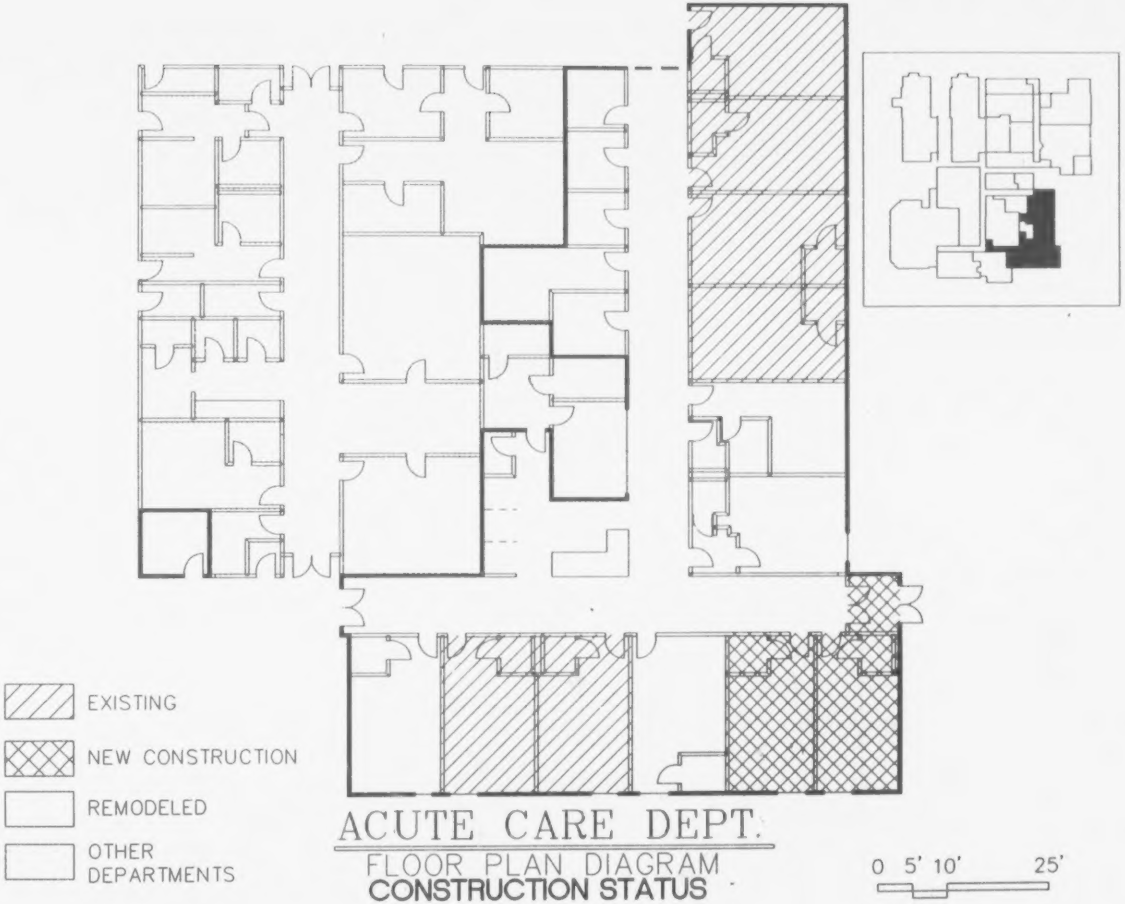
Area Space Summary - Acute Care Nursing	Area SF	Total SF
Patient Rooms*		
21 Patient Beds (see previous page)		3,140
SUBTOTAL NSF		3,140
*Count does not include labor beds or bassinets		
Support Areas		
Nurses Charting, Control and Crash Cart	1 @ 200	200
Medication Alcove	1 @ 30	30
Physician's Charting & Dictation Alcove	2 @ 30	60
Staff Toilet	1 @ 30	30
Nourishment Kitchen	1 @ 40	40
Clean Utility	1 @ 100	100
Soiled Utility	1 @ 100	100
Equipment Storage	1 @ 110	110
Exam and Treatment	1 @ 140	140
Staff Lockers and Lounge (15 lockers)	1 @ 80	80
Office - Head Nurse	1 @ 80	80
Consultation Room	1 @ 110	110
Janitor Closet	1 @ 40	40
Patient/Visitor Lounge	1 @ 150	150
Tub/Wheelchair Shower	1 @ 100	100
Wheelchair and Stretcher Alcove	2 @ 30	60
Sitz Bath	1 @ 30	30
Gowning Alcove (OB)	1 @ 20	20
Radio Room (Village Health Night Calls)	1 @ 80	80
SUBTOTAL NSF		1,560
TOTAL NSF		4,700



ACUTE CARE DEPT.

FLOOR PLAN DIAGRAM

MEDICAL SURGERY 2 BED
MEDICAL SURGERY 2 BED
MEDICAL SURGERY 2 BED
MEDICAL SURGERY 2 BED
MEDICAL SURGERY 1 BED
ISOLATION 1 BED
TUB
CLEAN
UTILITY
SOILED
UTILITY
CONSULT/EXAM
HEAD NURSE
NURSE STATION
CRASH CART BELOW COUNTER
MEDICAL SURGERY 2 BED
MEDICAL SURGERY 2 BED
SPECIAL CARE 2 BED
PEDIATRIC 2 BED
OBSTETRICAL 2 BED
OBSTETRICAL 1 BED
EQUIP. STOR.
STAFF TOILET
MEDICATION ALCOVE
NOURISHMENT
PHYSICIAN'S CHART/DICTATION
OTHER DEPARTMENTS
0 5' 10' 25'



ACUTE CARE DEPT.

FLOOR PLAN DIAGRAM
CONSTRUCTION STATUS

▨ EXISTING
▩ NEW CONSTRUCTION
☐ REMODELED
☐ OTHER DEPARTMENTS
0 5' 10' 25'

NURSERY

The Nursery is responsible for the treatment and care of all newborns. Upon delivery, a newborn is placed in the care of a physician. When the baby has been stabilized, he is transferred from the Delivery Room to the Nursery. If the newborn requires monitoring, he is either placed in the observation nursery and connected to monitoring equipment or is connected to monitoring in the full-term nursery. Healthy newborns are placed in open bassinets in the full-term nursery. Nursing personnel observe the newborns from the nurses station and workroom through windows.

Newborns are taken from the Nursery to their mothers during feeding time and as desired by their mothers. If the mother desires it, the newborn may remain in the mother's room on a 24-hour basis. This option is called Rooming-In.

The nursing staff follow careful procedures to avoid any contamination of the newborns in the Nursery. Before entering the Nursery, the staff are fully-gowned in the workroom. Between treating newborns, the staff wash their hands to avoid cross contamination. For special treatments or examinations, the newborn is taken to the examination room.

To permit family and friends to view the newborn without entering either the Nursery or the Obstetric Nursing Unit, a viewing window will be provided to a corridor.

Program Assumptions

Projected Number of Births = 240
Current Births 1983 = 202
Current Newborn Patient Days 1983 - 462

Nursery Average Length of Stay Factor

NLS (Assumed 2.8) 1983 = 2.7

Projected Newborn Average Daily Patient Load

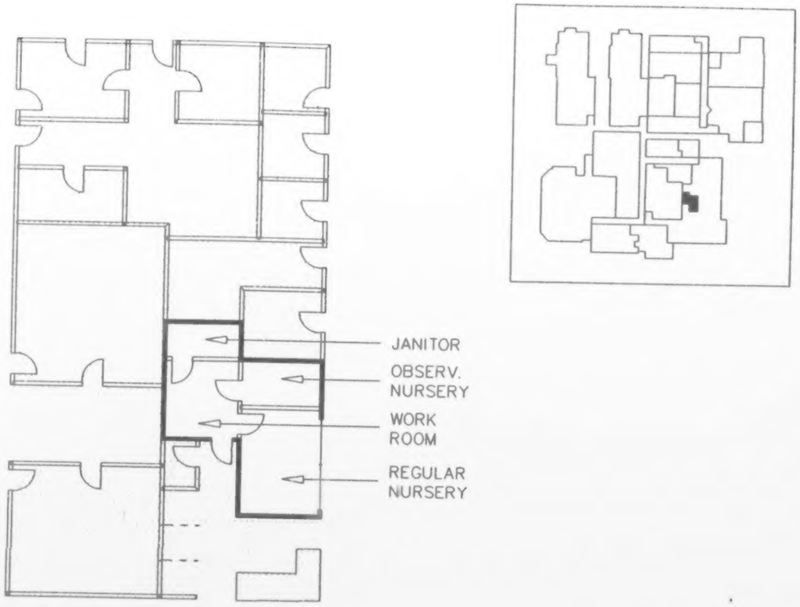
Projected Newborn Average Daily Patient Load = 2.3
Projected Number of Births 308 x 2.8 = 2.3

Staff Requirements

Staffed From Central Nurses' Station

Area Space Summary - Nursery

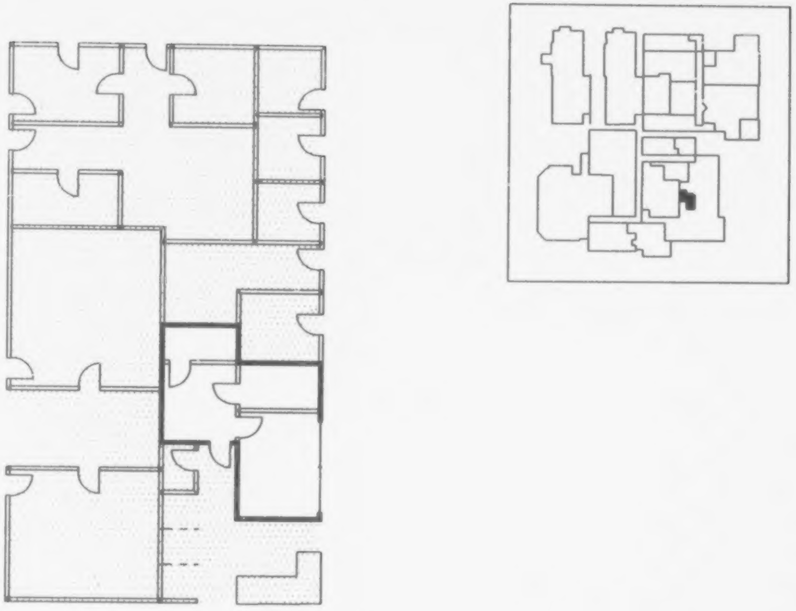
	Unit SF	Room SF	Total SF
Regular Nursery	5 @ 30	1 @ 150	150
Observation Nursery	1 @ 80	1 @ 80	80
Workroom & Examination Room		1 @ 100	100
Janitor Closet		1 @ 40	40
TOTAL NSF			370


JANITOR
OBSERV. NURSERY
WORK ROOM
REGULAR NURSERY

NURSERY DEPT.

FLOOR PLAN DIAGRAM

OTHER DEPARTMENTS
0 5' 10' 25'


▨ EXISTING
▩ NEW CONSTRUCTION
☐ REMODELED
░ OTHER DEPARTMENTS
0 5' 10' 25'

NURSERY DEPT.

FLOOR PLAN DIAGRAM
CONSTRUCTION STATUS

DELIVERY/SURGERY

The Delivery Department is responsible for the treatment and care of mothers and badies prior to, during, and immediately following birth. The Surgery Department is responsible for the treatment and care of patients immediately prior to, during, and immediately following surgery.

Both Delivery and Surgery are provided; they exist adjacent to each other so that they can share support areas such as anesthesia, storage, work areas, locker rooms, and equipment storage.

The single corridor concept is designed with a clean work corridor for the movement of staff and the arrival and distribution of materials, supplies, and instruments.

Patient movement, housekeeping functions, and removal of soiled materials from the operating room upon completion of a procedure take place in the corridor.

Physicians and staff enter the clean work corridor after having donned clean scrub suits in the locker room. They then enter the delivery room or operating room following an appropriate scrub. Following cases, the return flow is via the single corridor.

The circulating nurse will move between operating room and/or delivery in the clean work area, where back-up supplies and flash sterilizers are provided.

Patients will receive pre-operative preparation within their rooms and then be transferred to the surgical suite on a stretcher. The patient will enter the operating room via the single corridor. Following the procedure, the patient returns to the patient room for recovery.

Anesthesia facilities are located on the single corridor adjacent to both the surgery and delivery rooms.

Program Assumptions

Deliveries

Projected Number of Deliveries		High = 342

Surgical Case Projections

Projected Surgical Cases	Low = 37	High = 101

Area Space Summary - Delivery Surgical

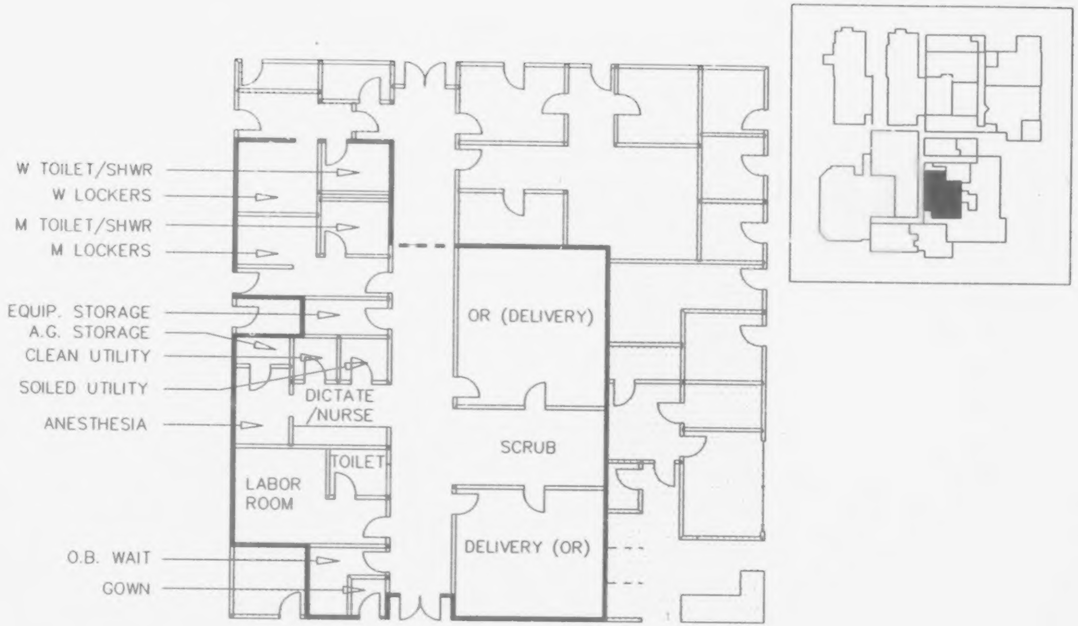
	Area SF	Total SF
Procedure Area - Surgery		
Operating Room - General	1 @ 400	400
Scrub Alcove - Shared	1 @ 60	60
Surgical Recovery - In Patient Room		
Recovery Isolation - In Patient Room		
Surgical Recovery Nursing Area - In Acute Care Nurses Station		
Clean Supply - Shared	1 @ 40	40
Soiled Utility - Shared	1 @ 40	40
Procedure Area - Delivery		
Delivery Room	1 @ 320	320
Scrub Alcove - (Share above)		
Labor Room (2 beds, one room with toilet)	1 @ 280	280
Patient Toilet	1 @ 40	40
Birthing Room	1 @ 160	160
Delivery Clean Work Area - (Share above)		
Soiled Holding & Clean-up - (Share above)		

Delivery Recovery Area

- Delivery Recovery (In Patient Room)
- Delivery Recovery Nursing Area (Acute Care Nurses Station)
- Clean Supply (Share above)
- Soiled Utility (Share above)

Area Space Summary - Delivery Surgical (Continued)

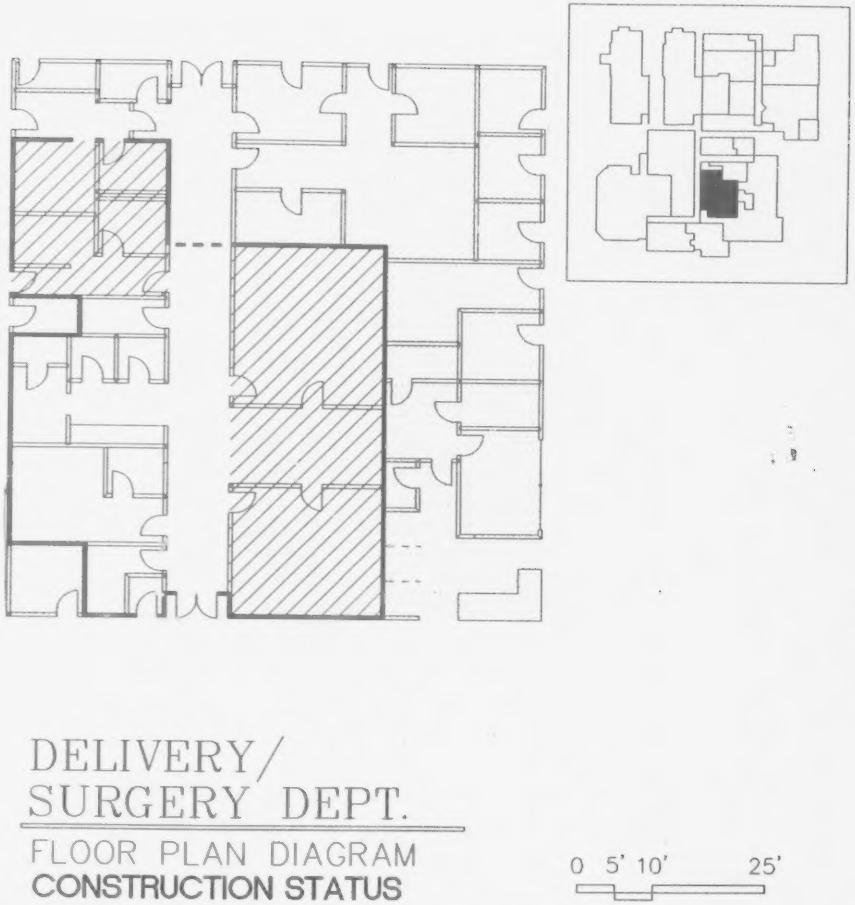
	Area SF	Total SF
Support Area		
OR/OB Control (Acute Care Nurses Station)		
Patient Holding (Patient Room)		
Anesthesia Wookroom	1 @ 80	80
Anesthesia Gas Storage	1 @ 30	30
Stretcher Alcove	1 @ 75	75
Equipment Storage	1 @ 100	100
Lockers - Male	1 @ 100	100
Toilet - Male	1 @ 30	30
Shower - Male	1 @ 20	20
Lockers - Female	1 @ 140	140
Toilet - Female	1 @ 30	30
Shower - Female	1 @ 20	20
Lounge OR/OB	1 @ 80	80
Dictation	2 @ 20	40
Administrative Area		
Office, Chief Nurse (Acute Care Nursing Unit)	1 @ 100	100
TOTAL NSF		2,185


W TOILET/SHWR
W LOCKERS
M TOILET/SHWR
M LOCKERS
EQUIP. STORAGE
A.G. STORAGE
CLEAN UTILITY
SOILED UTILITY
ANESTHESIA
O.B. WAIT
GOWN
OR (DELIVERY)
SCRUB
DELIVERY (OR)
DICTATE
/NURSE
TOILET
LABOR
ROOM

DELIVERY/ SURGERY DEPT.

FLOOR PLAN DIAGRAM

OTHER
DEPARTMENTS
0 5' 10' 25'



▨ EXISTING

▦ NEW CONSTRUCTION

☐ REMODELED

☐ OTHER DEPARTMENTS

DELIVERY/
SURGERY DEPT.

FLOOR PLAN DIAGRAM
CONSTRUCTION STATUS

LABORATORY/PATHOLOGY

The Laboratory is a primary diagnostic service of the hospital shared by both inpatients and outpatients.

Specimens from inpatients will be collected by the Laboratory from the nursing unit. Specimens from outpatients will be collected in the Laboratory by use of the specimen toilets and venipuncture booths. Units of blood are supplied from the adjacent Blood Donor room. In cases of extreme emergency the major blood unit supplier is Bloodbank of Alaska.

Specimens are logged in and initially processed at a central point for distribution throughout the Laboratory. As tests are completed, the physician is notified of the results and this notification is made a part of the patient record.

Some tests requested may not be done in the Laboratory because of cost considerations or a lack of proper equipment. These tests will be logged in and then sent to a contract laboratory for analysis. When returned, the results will be reported to the initiating physician and entered on the patient record.

Laboratories are a complex organization of interwoven disciplines. In the NSHC Hospital, the identified disciplines are:

Blood Bank	The preparation of blood and blood products for transfusions.
Hematology and Coagulation	The study of the components of blood and blood forming tissues.
Phlebotomy	Drawing of blood samples between 350 and 550 blood draws per month.

Dispatch	Sends samples to reference lab.
Serology	Serological/immunological analysis.
Chemistry and Urinalysis	Biochemical analysis of blood, urine, and other body fluids.
Microbiology	The study of microoganisms including bacteria, mycology, parasites, and viruses. (Large table for media makeup.)
Histology/Cytology	The study of the microscopic and gross anatomy of the body tissue. (Sent out, not done in state.)

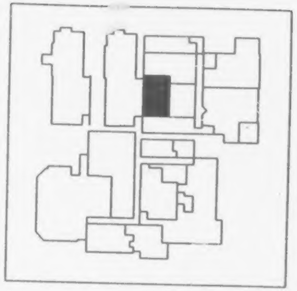
Laboratory equipment and procedures change frequently. The laboratory may be designed as one open room with flexible/moveable cabinetry and plumbing system for Blood Bank and Serology, Hematology and Coagulation, and Chemistry. Enclosed rooms may be considered for medical prep. Microbiology must be separate from other lab functions. Consideration should be given to a separate room for blood donor plebotomy. (Serving 350-550 blood draws per month.) Within the lab, an outpatient and village accession area with desk and counter space needs to be provided (serving 1200 - 1500 patients per month). All areas/disciplines need adequate space to store records, supplies, reference materials and maintenance records.

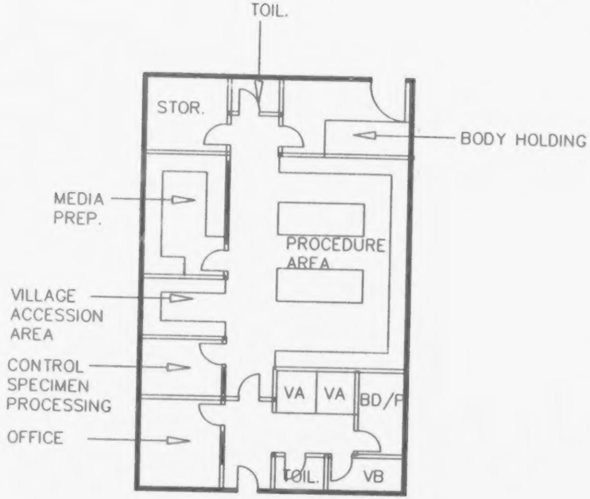
The morgue is used only occasionally for autopsies. Instead, autopsies are usually performed in Anchorage by contract facilities. However, it is used for identification of persons by family members and law enforcement officers, as well as for preliminary forensic studies if needed. This latter use does not call for complicated equipment, etc., but rather a counter-top area for specimen collection and recording of information.

Area Space Summary - Laboratory/Pathology

	Area SF	Total SF
Procedure Area		
Chemistry (2 Machines)	1 @ 200	200
Hematology (1 Machine)	1 @ 100	100
Bacteriology and Serology	1 @ 100	100
Blood Bank	1 @ 120	120
Specimen Processing	1 @ 120	120
Coaculation (Equipment & Machine)	1 @ 60	60
Support Area		
Specimen Toilet	1 @ 40	40
Venipuncture/Adults	1 @ 20	20
Venipuncture/Adults	1 @ 20	20
Venipuncture/Babies	1 @ 20	20
Storage	1 @ 100	100
Media Prep	1 @ 120	120
Blood Donor/Phlebotomy (Chair & Supplies)	1 @ 120	120
Anatomical Lab Area		
Body Holding	80	80
Office/Staff Area		
Office, Pathologist (Share with C.T.)		
Office, Chief Technical	1 @ 120	120
Store Room	1 @ 160	160
Record Storage, Computer	80	80
TOTAL NSF		1,580

NSHC08/106

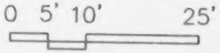


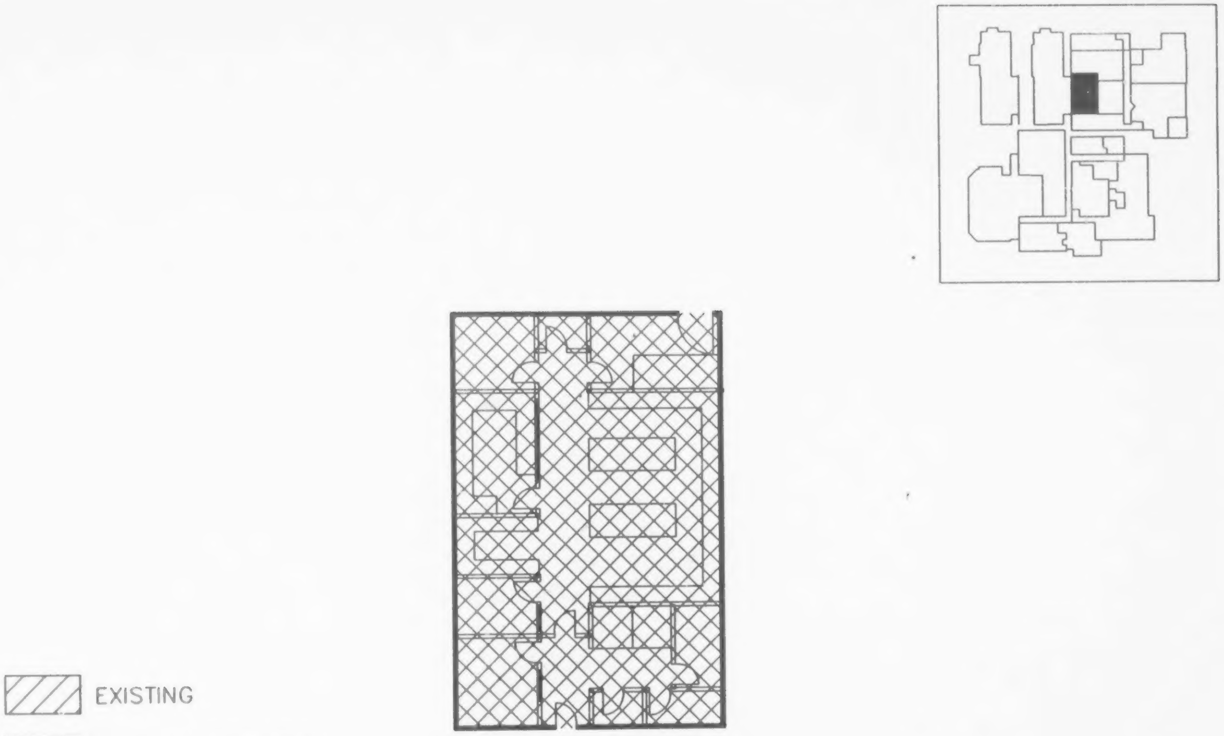

TOIL.
STOR.
BODY HOLDING
MEDIA PREP.
PROCEDURE AREA
VILLAGE ACCESSION AREA
CONTROL SPECIMEN PROCESSING
VA
VA
BD/P
OFFICE
TOIL.
VB

LABORATORY/PATHOLOGY

FLOOR PLAN DIAGRAM

☐ OTHER DEPARTMENTS




▨ EXISTING
▩ NEW CONSTRUCTION
☐ REMODELED
░ OTHER DEPARTMENTS
0 5' 10' 25'

LABORATORY/PATHOLOGY

FLOOR PLAN DIAGRAM
CONSTRUCTION STATUS

RADIOLOGY

Operation of the Radiology Department is based on the efficient handling of patients, staff, films, and consulting physicians.

Upon arrival, both inpatients and outpatients are directed to the patient holding area. A Radiographic Technician takes the patient from the waiting area to the Radiographic Room. Inpatients on stretchers are taken directly into the room. Ambulatory patients required to gown are directed to the dressing booths immediately adjacent to the Radiographic Room entrance. Adjacent to each Radiographic Room are recommended a dressing booth and one toilet room.

Radiographic Rooms may be equipped with one of three capabilities: Radiographic-Diagnostic, Radiographic-Fluoroscopic, or future Radiographic-Tomographic equipment. Each room is to be capable of normal X-ray procedures; this is known as Radiographic-Diagnostic equipment. In addition, equipment in Radiographic-Fluoroscopic Rooms is to be capable of Fluoroscopic procedures.

The control area in the Radiographic Rooms should be located near the darkroom to permit rapid movement for film processing. The film is taken immediately after exposure to the darkroom pass box and passed through the film processor. Depending on the workload, the patient may either remain on the Radiographic table or wait in the dressing booth until the film has been processed and checked for quality.

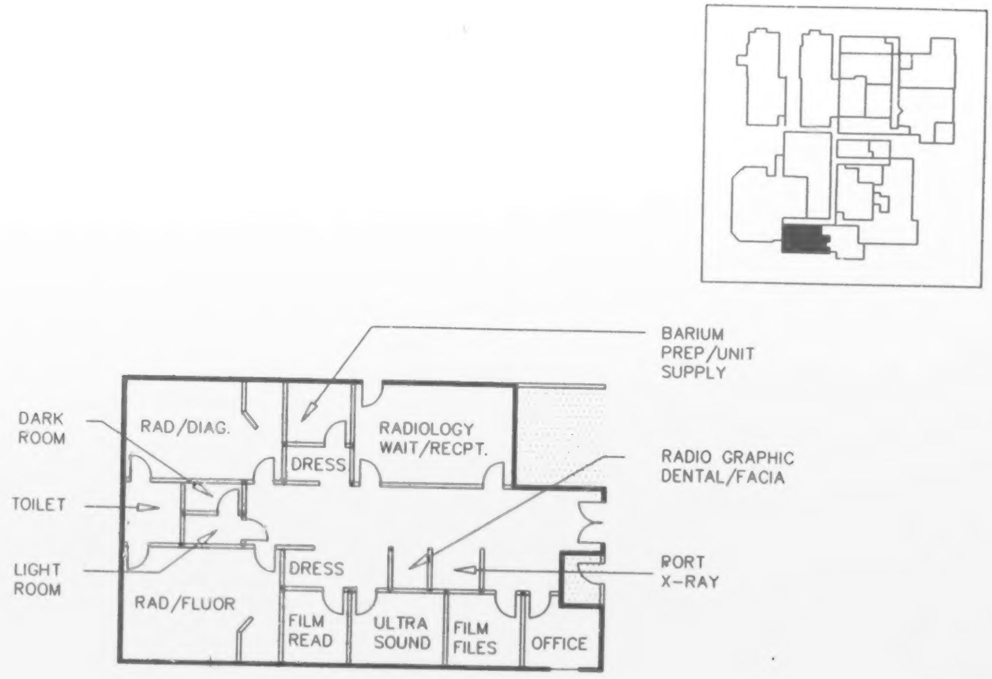
After checking, the film is sent to the Radiologist for reading after being read initially by the initiating physician.

Staff Requirements	Number
Radiologist - One visit per 2 months	
Clinician	
X-Ray Technologist	2.65
X-Ray Technologist Special Procedure	
Dark Room Technician	
Clerk Typist	
Secretary	
TOTAL	2.65

Area Space Summary - Radiology

	Area SF	Total SF
Procedure Area		
Radiographic - Dental/Facia	1 @ 30	30
Radiographic - Diagnostic	1 @ 300	300
Radiographic - Fluoroscopic	1 @ 300	300
Ultra-Sound	1 @ 120	120
Dressing Booth	2 @ 20	40
Toilet	1 @ 30 + 1 @ 45	75
Darkroom (including light work area)	1 @ 60	60
Portable X-Ray Alcove	1 @ 30	30
Barium Prep Area	1 @ 20	20
Unit Supply	1 @ 40	40
Administrative Area		
Film Reading	1 @ 80	80
Film Files and Work Area	1 @ 120	120
Office, Unit Supervisor	1 @ 100	100
Public/Staff Area		
Inpatient Holding Area	1 @ 70	70
Outpatient (See Public Facilities Waiting)		
TOTAL		1,385

NSHC08/104

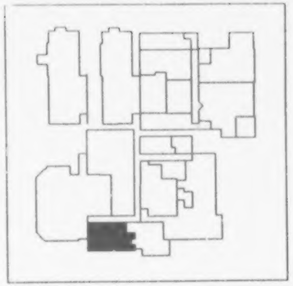

BARIUM PREP/UNIT SUPPLY
DARK ROOM
RAD/DIAG.
RADIOLOGY WAIT/RECPT.
DRESS
RADIO GRAPHIC DENTAL/FACIA
TOILET
LIGHT ROOM
DRESS
PORT X-RAY
RAD/FLUOR
FILM READ
ULTRA SOUND
FILM FILES
OFFICE

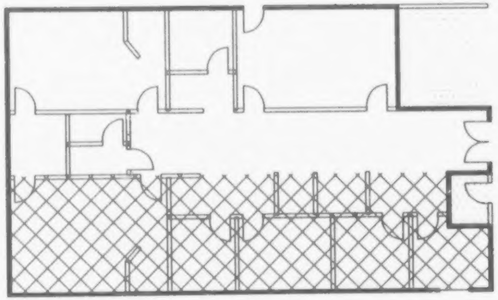
RADIOLOGY DEPT.

FLOOR PLAN DIAGRAM

▨ OTHER DEPARTMENTS

0 5' 10' 25'





▨ EXISTING

▩ NEW CONSTRUCTION

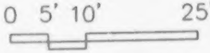
☐ REMODELED

☐ OTHER DEPARTMENTS

RADIOLOGY DEPT.

FLOOR PLAN DIAGRAM

CONSTRUCTION STATUS



EMERGENCY DEPARTMENT

The Emergency Department is intended to serve patients with health care needs requiring prompt medical attention on a 24 hour basis. Nursing staff are provided 24 hours per day. Physicians are regularly available from 8 am to 6 pm, and are on call the remaining hours.

During normal Outpatient Department hours, the Emergency Room is used to treat only injuries and illnesses demanding prompt medical treatment. Patients presenting themselves to the emergency room during normal OPD hours are triaged, provided emergency care or sent to the Outpatient Department, if appropriate.

During hours when the Outpatient Department is closed, the Emergency Department receives all ambulatory patients with a problem demanding prompt medical treatment or that would normally be handled in the Outpatient Department. An ideal design fully integrates swinging examination rooms from OPD into the Emergency Department.

The Emergency Department consists of a triage/nurse station, treatment room, exam rooms, and supply and utility rooms. The examination rooms may swing for use in the Outpatient Department.

An ambulance entrance is required. The entrance should be covered and it is desirable to be enclosed.

Emergency Room facilities must meet JCAH requirements:

> "The design of the emergency department/service area shall facilitate the visual and auditory privacy of the patients, without compromising patient care. Sufficient space shall be provided for the examination and treatment of patients seeking emergency care, particularly for the management of patients with life-threatening conditions."

Program Assumptions

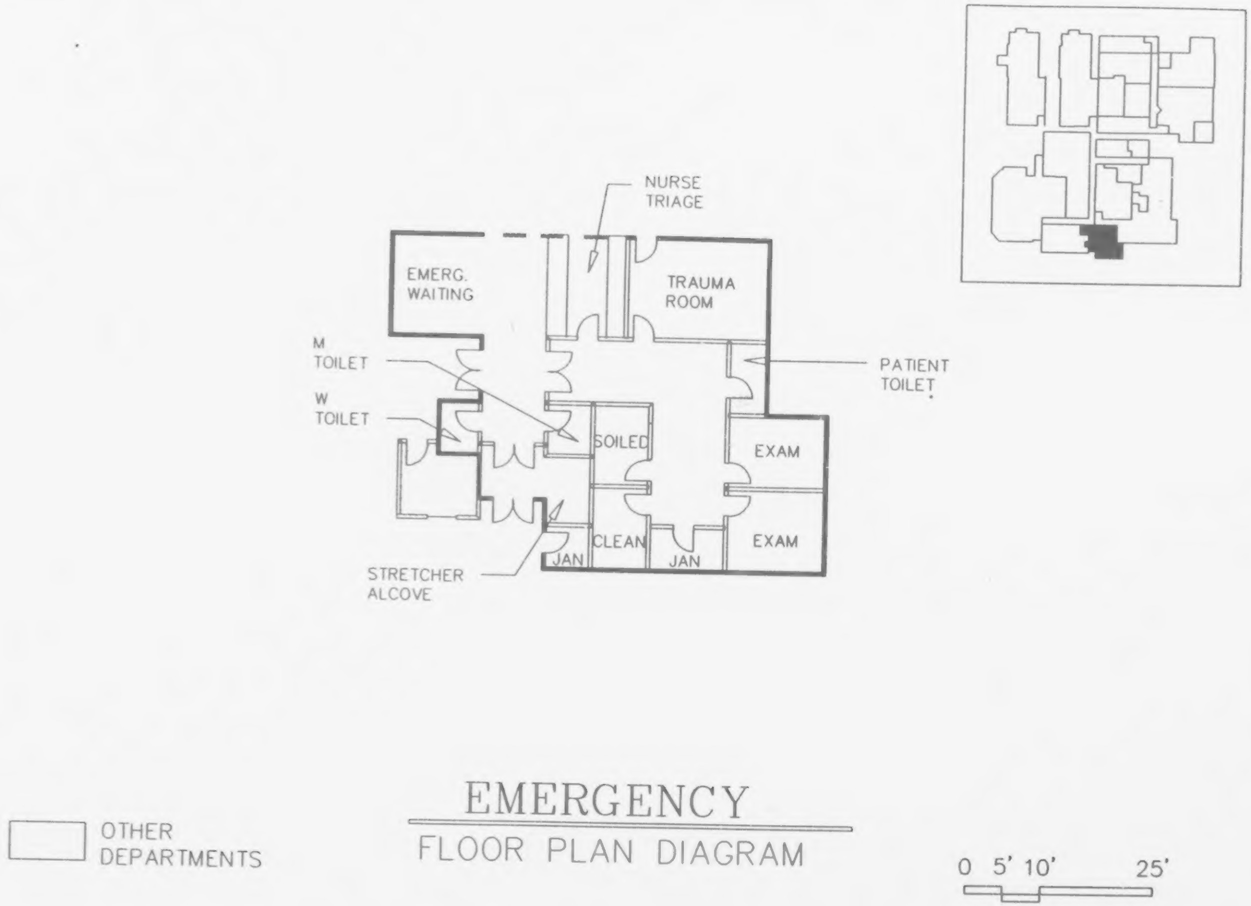
279/1000 Average Use Rate

Projected Number of Emergency Visits

1990 = 2,645
1995 = 2,937
2000 = 3,385

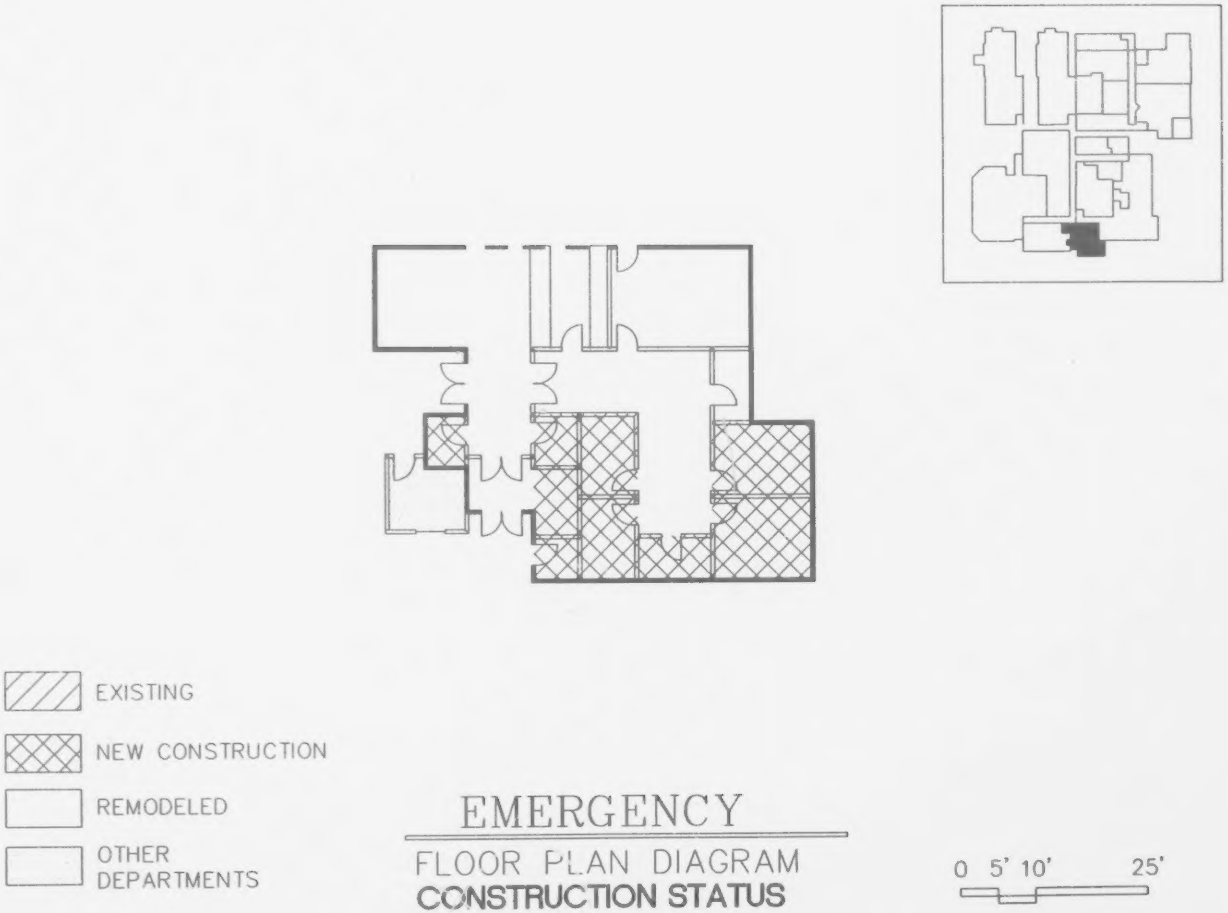
Area Space Summary - Emergency

	Area SF	Total SF
Emergency Exam and Treatment Rooms	2 @ 110	220
Emergency Trauma Room	1 @ 320	320
Patient Toilet	1 @ 45	45
Waiting Area	1 @ 200	200
Nurse Triage/Control	1 @ 120	120
Public Toilet	2 @ 30	60
Clean Utility Room	1 @ 80	80
Soiled Utility Room	1 @ 100	100
Stretcher and Wheelchair Alcove	1 @ 60	60
Equipment Room	1 @ 80	80
Janitor Closet - Interior & Exterior	2 @ 40	80
TOTAL NSF		1,365


NURSE TRIAGE
EMERG. WAITING
TRAUMA ROOM
M TOILET
W TOILET
PATIENT TOILET
SOILED
EXAM
EXAM
CLEAN
JAN
JAN
STRETCHER ALCOVE
OTHER DEPARTMENTS
0 5' 10' 25'

EMERGENCY

FLOOR PLAN DIAGRAM


▨ EXISTING
▩ NEW CONSTRUCTION
☐ REMODELED
☐ OTHER DEPARTMENTS
0 5' 10' 25'

EMERGENCY

FLOOR PLAN DIAGRAM

CONSTRUCTION STATUS

OUTPATIENT DEPARTMENT

The Outpatient Department is the initial contact point for patients desiring medical attention. During normal clinic hours, patients may be seen either with or without an appointment. Specialty clinics are held at preset hours during the week.

Before being seen in the Outpatient Department, patients must first sign in at the reception desk to have their health records pulled. Patients with appointments are generally to be seen first, making way for those with more emergent conditions. An intercom system to call patients should link the outpatient area and the waiting room.

The patient is seen first by the nurse and evaluated for triage purposes. Vital signs and a brief history are taken. Once seen by a Primary Care Provider (PCP), the patient may be sent to various departments for tests (Radiology, Laboratory), medication (Pharmacy), or other types of care (treatment room, Inpatient).

The PCPs generally move between two examination rooms while working in the clinic. This allows support personnel to complete treatments, such as giving shots, changing bandages, etc.

Specialty Clinics with visiting specialists must be accommodated within the Outpatient Department. These clinics are highly intensive and 20-40 patients are often present at one time.

The Treatment Room will be used to perform special procedures. A soundproof area is built into the Audiology Clinic for testing purposes. An examination room equipped for ENT exams should be provided.

Within the Emergency Department, is located the telephone communication center for physician contact with community health aides, with remote radio backup. Consideration should be given to the entire communications linkage system, as there are also radio communications with Search and Rescue and Police/Ambulance Dispatch needed. Centralizing all such equipment is important.

Program Assumptions

1845/1,000 Average Use Rate			
Projected Number of Primary Care Providers		=	5
Projected Number of Outpatient Visits	1990	=	17,745
	1995	=	19,706
	2000	-	22,710

Projected Outpatient Work Stations

Work Stations	5.5

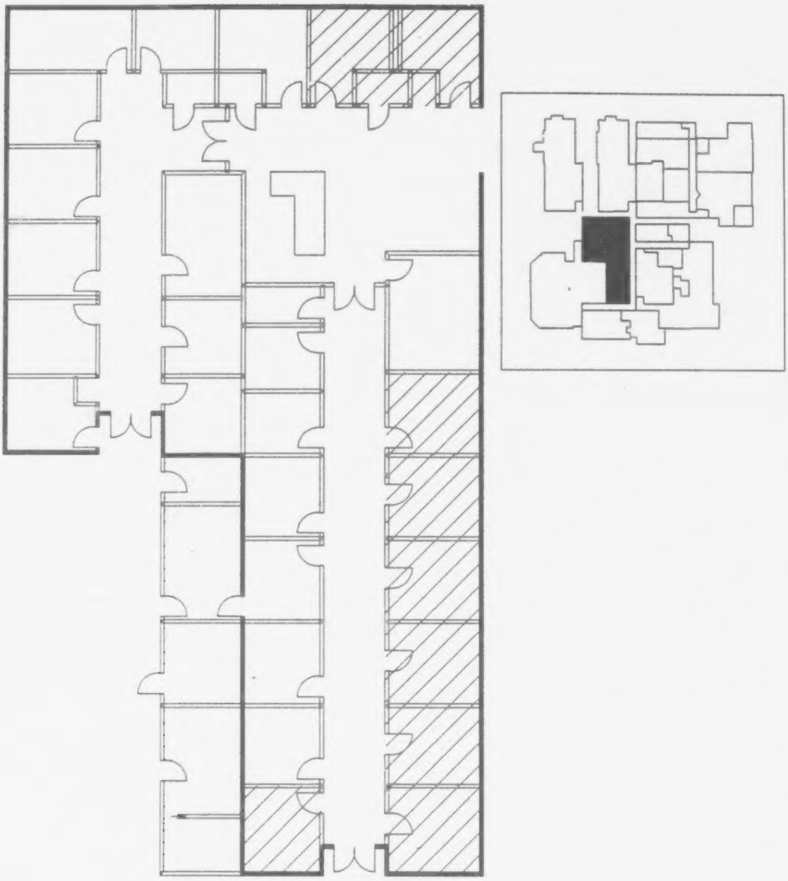
Specialty Clinics

Space Required for 2 Exam Rooms, 1 Office + 1 ENT Room

Staff	Number
Primary Care Providers (PCP)	5
Head Nurse	1
Registered Nurse	2
Licensed Practical Nurse	
Nursing Assistant	1
Clerk, Receptionist	2
Patient Driver	1

Area Space Summary -Outpatient Department

	Area SF	Total SF
Treatment Area		
Radio Room	1 @ 160	160
Physician's Office	6 @ 110	660
Examination Room (4.5 - 5.5 Work Stations)	12 @ 110	1,320
ENT Exam Room (40,000+)	1 @ 140	140
SUBTOTAL NSF		2,280
Public and Support Area		
Nurses Station - OPD	1 @ 140	140
Vital Signs	1 @ 80	80
Treatment Room	1 @ 140	140
Clean Utility	1 @ 80	80
Soiled Utility	1 @ 80	80
Patient Toilet	2 @ 30	60
Janitor Closet	1 @ 40	40
Wheelchair Alcove	1 @ 60	60
SUBTOTAL NSF		680
TOTAL NSF		2,960



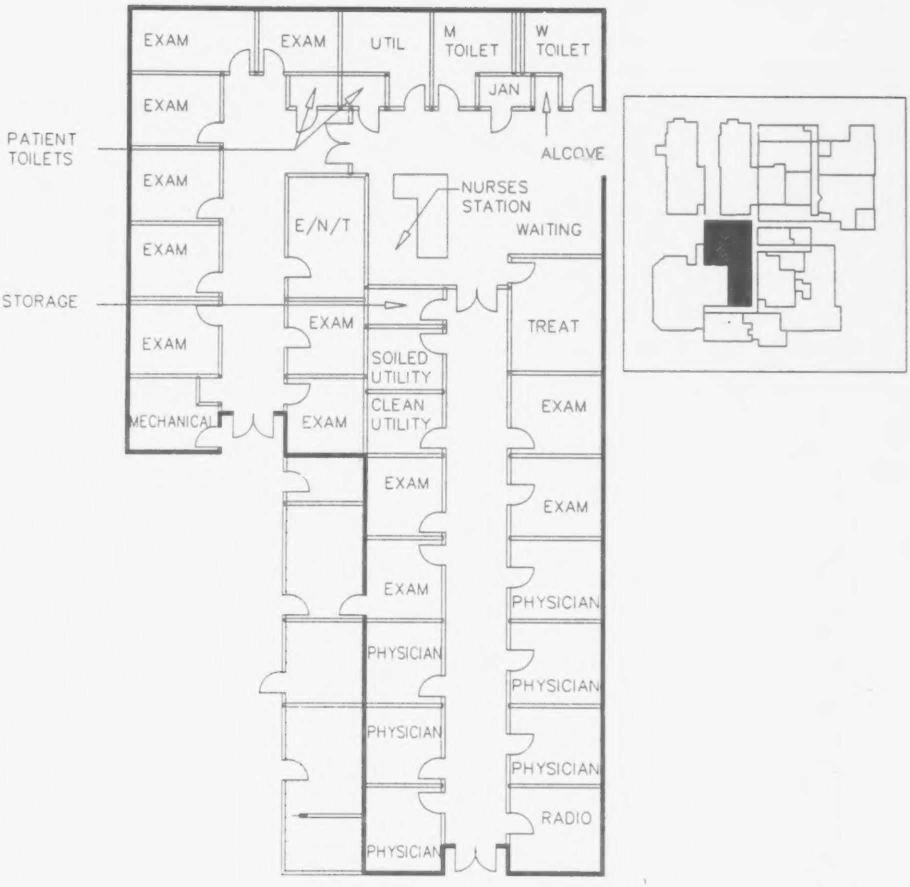
OUTPATIENT

FLOOR PLAN DIAGRAM
CONSTRUCTION STATUS

☐ REMODELED ▨ EXISTING

☐ OTHER DEPARTMENTS ▦ NEW CONSTRUCTION

0 5' 10' 25'


EXAM
EXAM
UTIL
M TOILET
W TOILET
JAN
EXAM
PATIENT TOILETS
ALCOVE
EXAM
E/N/T
NURSES STATION
WAITING
EXAM
STORAGE
EXAM
TREAT
EXAM
SOILED UTILITY
CLEAN UTILITY
MECHANICAL
EXAM
EXAM
EXAM
EXAM
EXAM
PHYSICIAN
PHYSICIAN
PHYSICIAN
PHYSICIAN
PHYSICIAN
PHYSICIAN
RADIO
PHYSICIAN

OUTPATIENT

FLOOR PLAN DIAGRAM

CONSTRUCTION STATUS

☐ REMODELED ▨ EXISTING

☐ OTHER DEPARTMENTS ⊠ NEW CONSTRUCTION

0 5' 10' 25'

PHYSICAL THERAPY

The Physical Therapy Department is responsible for the treatment of patients by hydrotherapy, exercise, or mobility. Treatments in each of the three areas require supervision by the therapists. Services are offered to acute care inpatients, long-term care/elder care facility patients and outpatients, and currently, limited services to patients in their homes.

Hydrotherapy usually involves treatment of an extremity by whirlpool to increase circulation, clean wounds, or otherwise treat epidermal disorders. With the high incidence of frostbite in the Arctic, this treatment is extensively employed.

Treatments in the exercise area are designed to exercise muscles which for some reason are not sufficiently toned or coordinated for normal functions. This treatment is utilized a great deal due to the large number of Workmen's Compensation claims.

Patients treated often have physical impairments due to stroke, muscular disease, limb dismemberment, or broken bones. These treatments include using gait exercises, stairs, mat exercises, bicycle, weight, and finger ladders.

Treatment in the mobility area includes muscular massage, heat or cold packs, paraffin, or a multitude of special treatments used to promote healing of the body's tissues.

Patients in Physical Therapy usually are treated daily or several times a week. The therapist often works with more than one patient at a time. This requires good visual and physical access between treatment areas. Cubicle curtains in place of walls may be considered to help accommodate this.

Projected Physical Therapy Procedures

Number Procedures by Service Setting - Inpatient*

Year	Incl. LTC	Excl. LTC	Outpatient
1990	930	414	870
1995	976	460	966
2000	1,046	530	1,112

* No physical therapy program currently exists for long term care. The estimates including long term care are based on recent inpatient service loads and may greatly understate the potential LTC patient load.

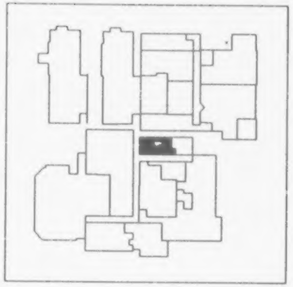
Program Assumptions and Determinants

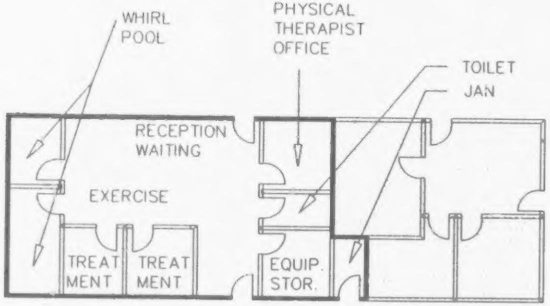
	1990	1995	2000
Projected number of Inpatient Beds	21	22	25

Staff Requirements	Number
Physical Therapists	1

Area Space Summary - Physical Therapy

	Area SF	Total SF
Whirlpool (1 L.Boy + 1 Comb.)	2 @ 120	240
Treatment (Cubicles)	2 @ 90	180
Exercise Area	1 @ 360	360
Equipment Storage	1 @ 100	100
Unit Supply	1 @ 40	40
Office, Physical Therapist	1 @ 100	100
Reception & Waiting (See Public Facilities)		
Patient Toilet - Training	1 @ 80	80
Janitor Closet	1 @ 40	40
TOTAL NSF		1,140

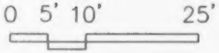


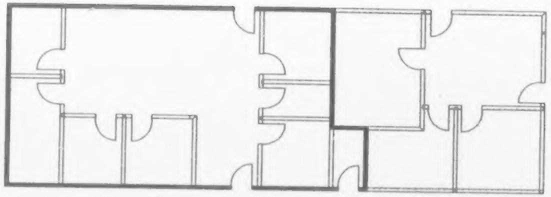

WHIRL
POOL
PHYSICAL
THERAPIST
OFFICE
TOILET
JAN
RECEPTION
WAITING
EXERCISE
TREAT
MENT
TREAT
MENT
EQUIP.
STOR.

PHYSICAL THERAPY

FLOOR PLAN DIAGRAM

☐ OTHER DEPARTMENTS





▨ EXISTING

▩ NEW CONSTRUCTION

☐ REMODELED

☐ OTHER DEPARTMENTS

PHYSICAL THERAPY

FLOOR PLAN DIAGRAM

CONSTRUCTION STATUS

0 5' 10' 25'

RESPIRATORY THERAPY

The Respiratory Therapy department is responsible for the treatment of patients requiring ventilation and other breathing related treatments.

Respiratory therapy treatments for inpatients are usually done in the patient room. This requires the transporting of the machines to each room. The patients are required to breath with the assistance of the ventilating machine. After the treatment, the machines are returned to the department for cleaning and calibration by the respiratory therapy technician. The machine is disassembled and cleaned by hand. The machine is reassembled with clean parts and returned to service. Many parts such as mouth pieces must be sterilized before they are reused. These parts are reassembled, packaged, and sent to Central Sterile and Reprocessing for gas sterilization. Since many items are disposable, adequate supplies must be maintained.

Projected Respiratory Therapy Procedures*

Year	Inpatient	Outpatient		Total
1990	1,688	247	=	1,935
1995	1,771	274	=	2,045
2000	1,889	316	=	2,215

* Includes estimates for long term care, 15 beds at 90% occupancy.

Program Assumptions and Determinates	1990	1995	2000
Projected number of Inpatient Days	3953	4390	5059
Projected number of Outpatient Visits	17745	19706	22710

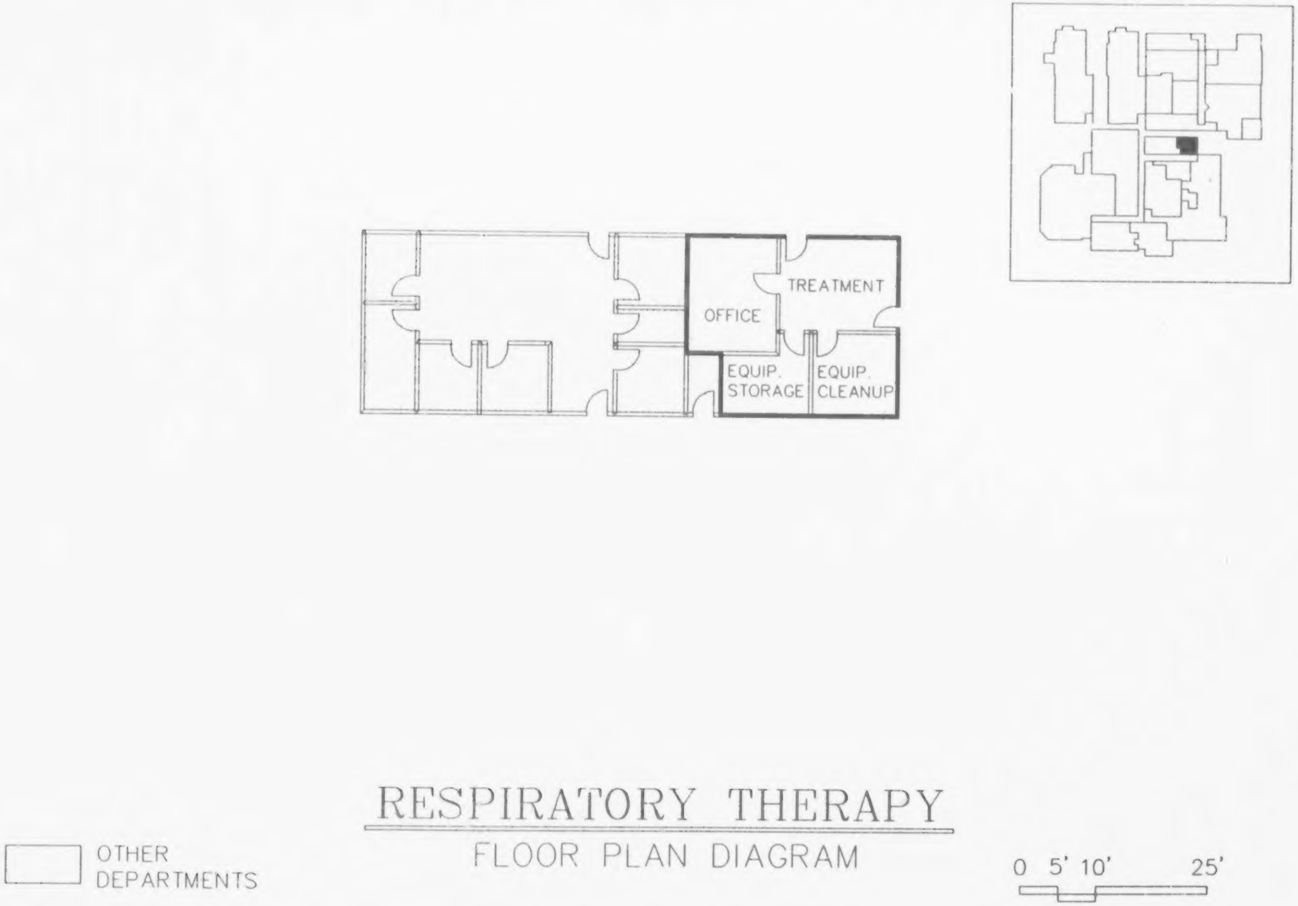
Respiratory Therapy Projections

Projected Inpatient Respiratory Therapy Treatments	1688	1771	1899
Projected Outpatient Respiratory Therapy Treatments	247	274	316
TOTAL Respiratory Therapy Treatments	1935	2045	2215

Staffing Requirements	Number
Respiratory Therapist	2

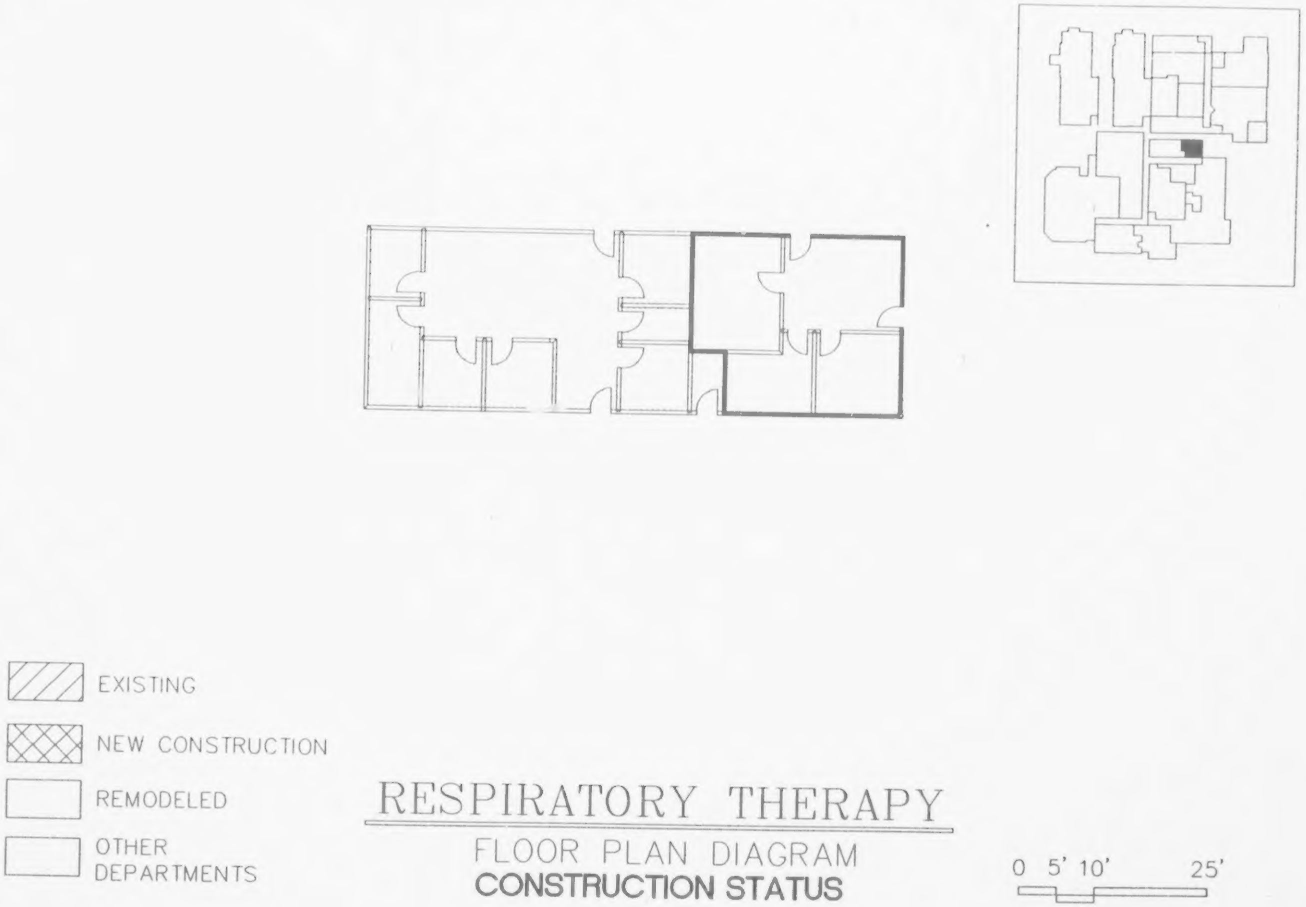
Area Space Summary - Respiratory Therapy

	Area SF	Total SF
Treatment Room	1 @ 120	120
Equipment Clean-up	1 @ 100	100
Equipment Storage	1 @ 150	150
Office (2 R.T.)	1 @ 160	160
TOTAL NSF		530


TREATMENT
OFFICE
EQUIP. STORAGE
EQUIP. CLEANUP
OTHER DEPARTMENTS
0 5' 10' 25'

RESPIRATORY THERAPY

FLOOR PLAN DIAGRAM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▩ NEW CONSTRUCTION
☐ REMODELED
☐ OTHER DEPARTMENTS
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RESPIRATORY THERAPY

FLOOR PLAN DIAGRAM

CONSTRUCTION STATUS

HEALTH RECORDS

The Health Records Department is responsible for management and organization of all patient treatment records for both inpatients and outpatients. Departmental personnel coordinate records preparation, transcription of records, and final assembly of the record. Health Records is also responsible for quality assurance and patient appointments.

The department performs two basic functions:

Records Storage: Patient records are held in active storage for seven years. At the end of the seven years, records are microfilmed and held permanently on microfile and microfiche.

An integrated patient record system incorporates patient information from the following departments: specialty clinic, outpatient clinic, audiology, eye clinic, dental clinic, and village health services.

Record Preparation and Retrieval: Patient records are assembled from treatment records such as lab slips, pharmacy prescriptions, nurse and physician notes, and dictated treatment notes. The department verifies the completeness of all records, secures the needed signatures, and places the record in storage.

Program Assumptions and Determinants

	1990	1995	2000
Projected Number of Admissions	1,060	1,177	1,357
Projected Outpatient Visits	17,745	17,745	22,710

Record Storage Projection

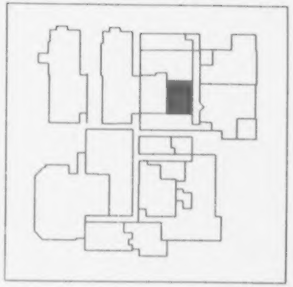
	1990	1995	2000
Active Record Storage = 7 years			
Projected Admissions x .5"/record x 7 years	3,719	4,120	4,750
Projected Outpatient Visits x .0625 x 7 years	7,763	8,621	9,936
Projected Active Record Inches	11,473	12,741	14,686

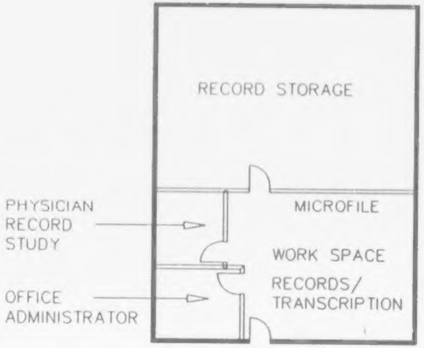
Staff Requirements

	Present Staff	Future Staff
Registered Medical Record Administrator	1	1
Medical Record Technician	3	5
Computer/Data Management Specialist		1
Transcriptionist	1	1
TOTAL STAFF	5	7

Area Space Summary - Health Records

		Area AF	Total SF
Reception/Registration O.P.		1 @ 100	100
Admitting/Interview I.P.		1 @ 100	100
Office - Administrator MRL		1 @ 120	120
Work Space - Records	3 @ 80	1 @ 240	240
Work Space - Transcription	1 @ 80	1 @ 80	80
Physician Record Study		1 @ 100	100
Active Record Storage		1 @ 900	900
Microfile		1 @ 120	120
TOTAL NSF			1,760

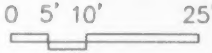


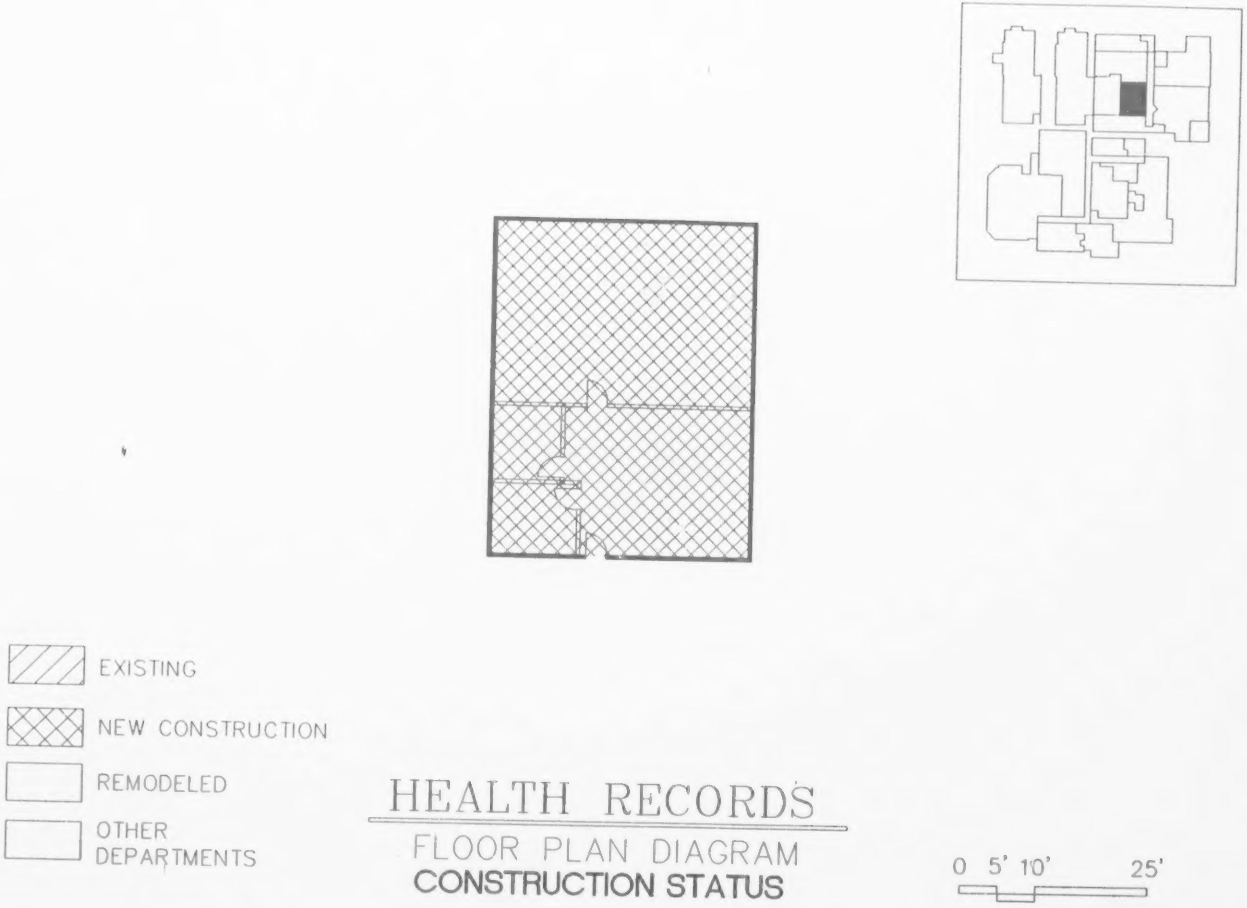

RECORD STORAGE
MICROFILE
WORK SPACE
RECORDS/
TRANSCRIPTION
PHYSICIAN
RECORD
STUDY
OFFICE
ADMINISTRATOR

HEALTH RECORDS

FLOOR PLAN DIAGRAM

☐ OTHER DEPARTMENTS





▨ EXISTING
▩ NEW CONSTRUCTION
☐ REMODELED
☐ OTHER DEPARTMENTS
0 5' 10' 25'

HEALTH RECORDS

FLOOR PLAN DIAGRAM

CONSTRUCTION STATUS

EMPLOYEE FACILITIES

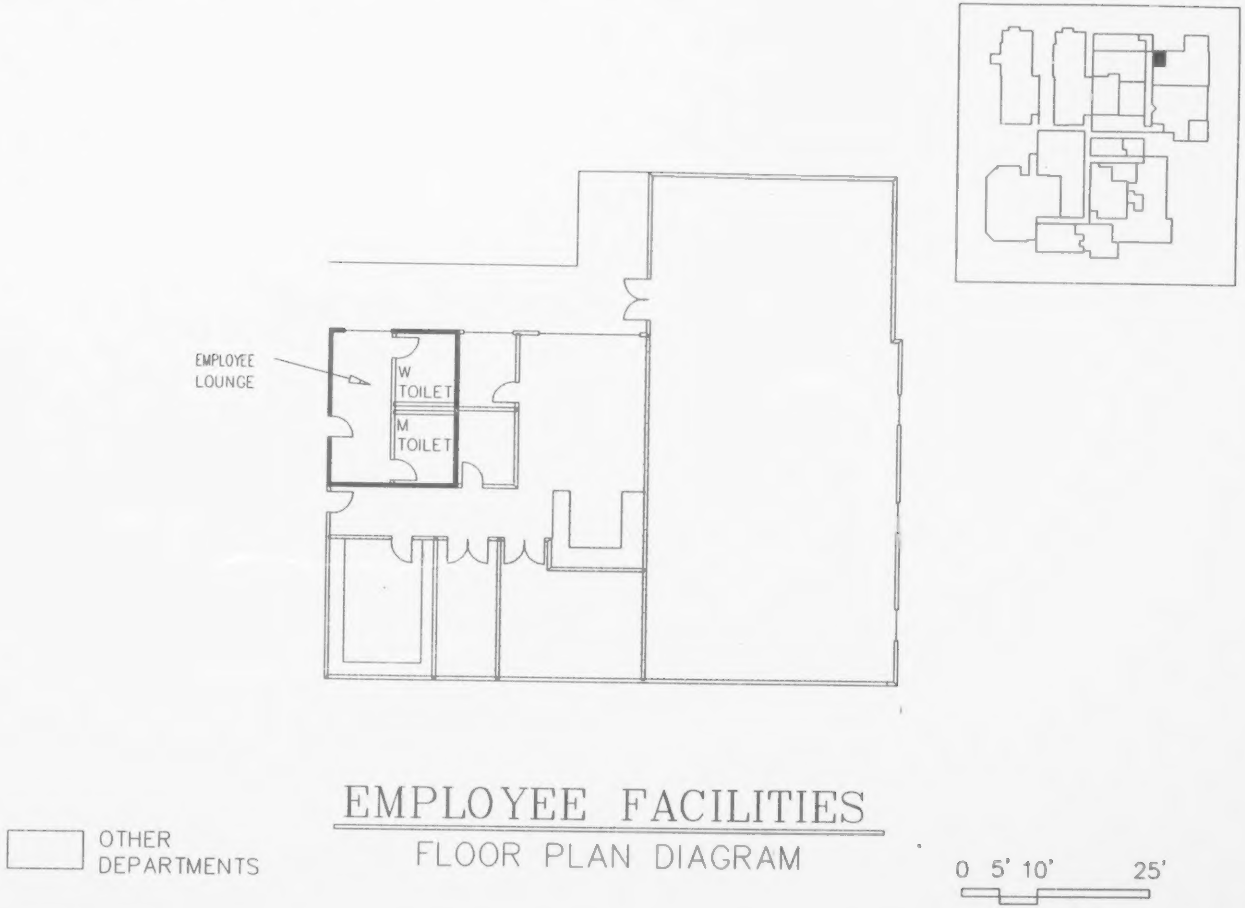
Employee facilities are provided centrally to serve employees working in the Central Stores, Dietetics Services, Housekeeping, Laundry, and Maintenance Departments. The facilities provided are to meet OSHA requirements for a lounge and provide lockers for coats and other articles. Toilet rooms with shower facilities are provided for the convenience of the staff.

Staff Requirements

	Number
Dietetics Service	7
Central Stores	5
Housekeeping	5
Laundry	3
Maintenance	4
TOTAL	24

Area Space Summary - Employee Facilities

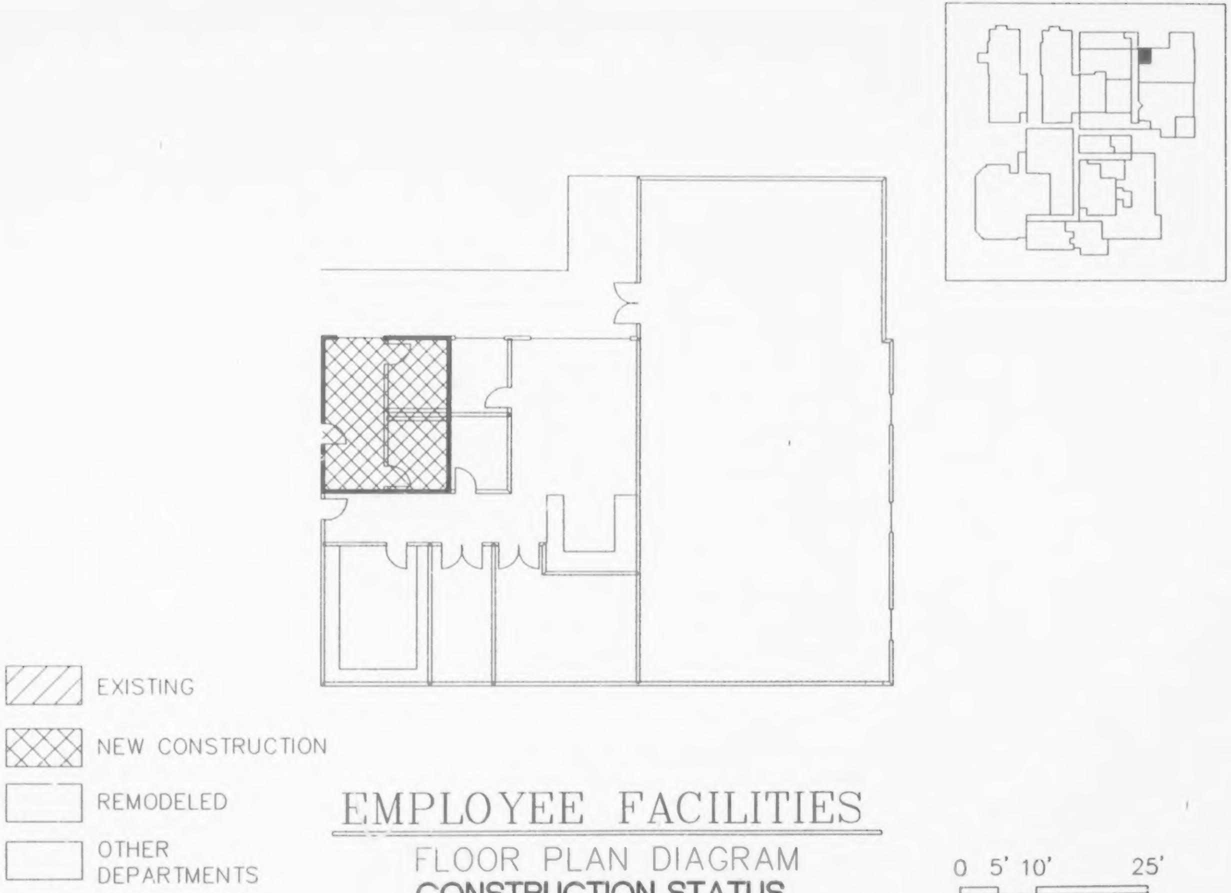
		Area SF	Total SF
Employee Lockers/Lounge - Male Employee Lockers/Lounge - Female	9 + 10 = 19x6 NSF	1 @ 114	114
Staff Toilet, Male		1 @ 45	45
Shower, Male		1 @ 30	30
Staff Toilet, Female		1 @ 45	45
Shower, Female		1 @ 30	30
TOTAL NSF			264



EMPLOYEE FACILITIES

FLOOR PLAN DIAGRAM

EMPLOYEE LOUNGE
W TOILET
M TOILET
OTHER DEPARTMENTS
0 5' 10' 25'


EXISTING
NEW CONSTRUCTION
REMODELED
OTHER DEPARTMENTS
0 5' 10' 25'

EMPLOYEE FACILITIES

FLOOR PLAN DIAGRAM

CONSTRUCTION STATUS

CONSULTING/TRAINING

The Consulting/Training Department has facilities available to and used by all departments of a Health Facility. The Department consists of Conference, Training and Library space. The most active training department is Village Health Services which is responsible for basic training and continuing education of approximately 40 primary community health aids and alternates. This training takes place 2-3 times annually in 2-3 week sessions. The Comprehensive Alcoholism Program provides training to approximately 10 counselors. This training takes pleace 3-4 times annually in 5-day sessions. The conference facilities are intended for the use of staff for management meetings, staff meetings, in-service training sessions, and departmental or interdepartmental meetings.

The conference facilities, in conjunction with the Training Demonstration Room, are intended to serve patients and the community in public health educational activities and health related community interest sessions. A Nutrition Demonstration Area is intended to be used for Nutrition Education Programs.

The conference facilities, in conjunction with the library, are intended to be used by the Medical Staff, Nursing Staff, and other professionals as a continuing education center and resource center.

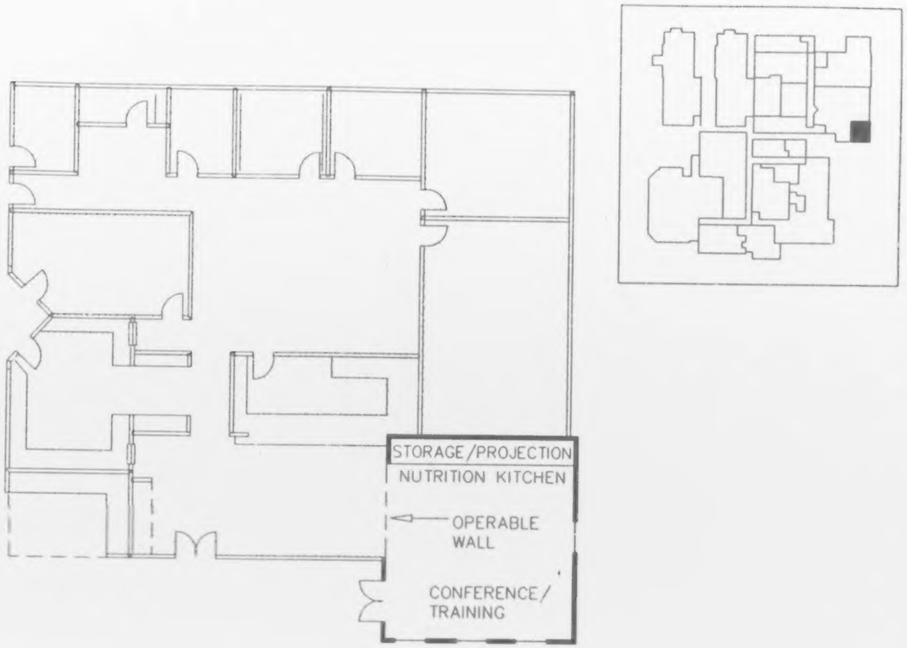
Staff Requirements

Total Facility Staff

Area Space Summary - Consulting/Training

	Area SF	Total SF
Office (Located in Administration*)		
Library (Located in Administration*)		
Conference Room	1 @ 300	300
Nutrition Demonstration Kitchen	1 @ 60	60
Training - Demonstration	1 @ 200	200
Storage/Projection Room	1 @ 20	20
TOTAL NSF		560

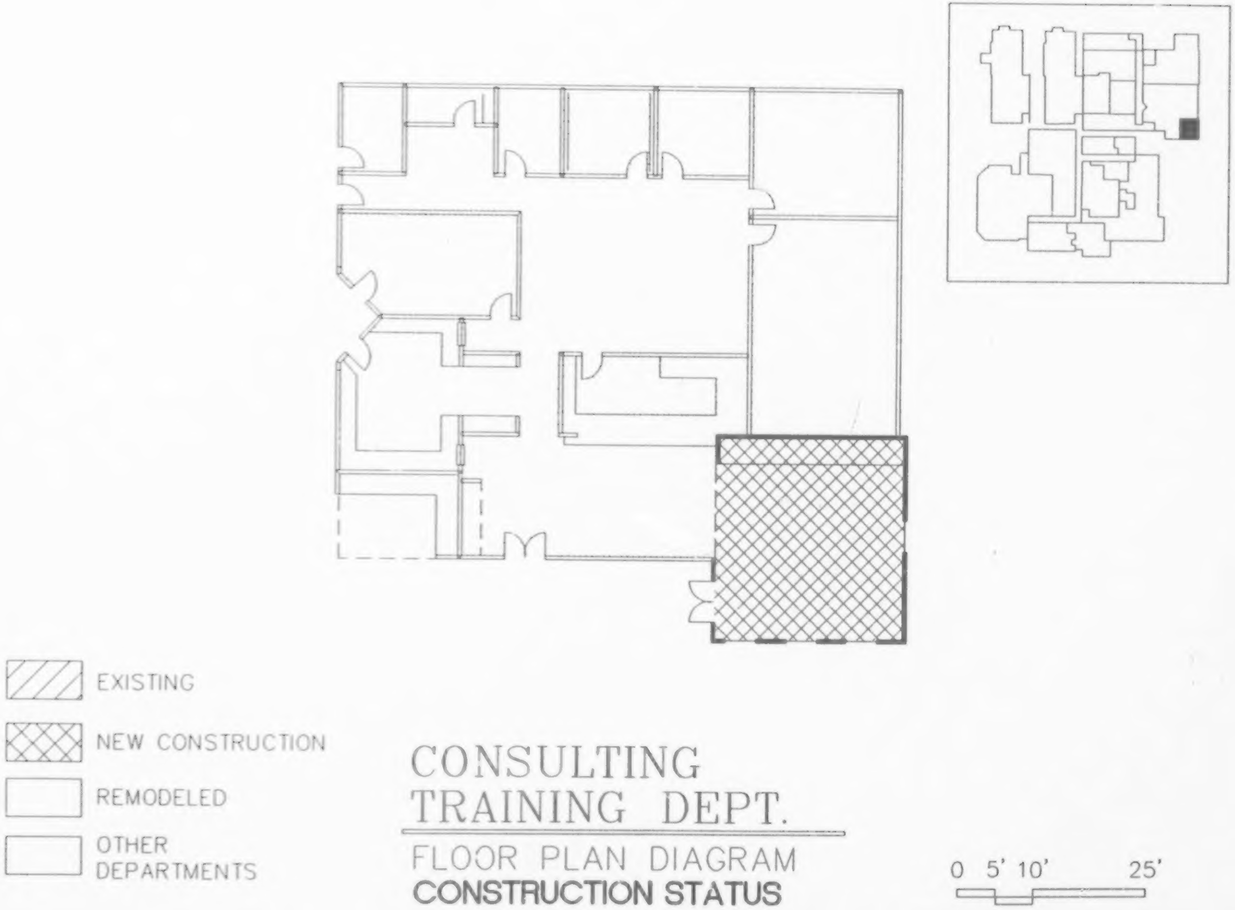
* Phase II Construction, not part of this project.


STORAGE/PROJECTION
NUTRITION KITCHEN
OPERABLE WALL
CONFERENCE/ TRAINING

CONSULTING TRAINING DEPT.

FLOOR PLAN DIAGRAM

OTHER DEPARTMENTS
0 5' 10' 25'



CONSULTING
TRAINING DEPT.

FLOOR PLAN DIAGRAM
CONSTRUCTION STATUS

▨ EXISTING
▩ NEW CONSTRUCTION
☐ REMODELED
☐ OTHER DEPARTMENTS
0 5' 10' 25'

PUBLIC FACILITIES

The Public Facilities serve as the information center and outpatient and visitor waiting area of the facility. The Lobby/Waiting area is the primary entrance. Health records, Pharmacy, Laboratory, Radiology and Outpatient department are close by. The waiting area is provided with handicapped accessible restrooms for public convenience. The switchboard information center is open during Outpatient Department hours to receive calls and direct patients and visitors.

The non-denominational chapel is functionally linked to the public facilities and serves as a room for consultation, patient and family support and patient-related religious ceremonies.

The gift shop is located adjacent to the public facilities.

Program Assumptions and Determinants

Projected Number of Outpatient Visits = 22,710
Number of Inpatient Beds = 25

Projected Daily Visitors

Projected Daily Inpatient Visitors (Beds x 2) = 50
Projected Daily Outpatient Visitors (OPV x .012) = 273
3 persons per OPV at 260 days annual operation

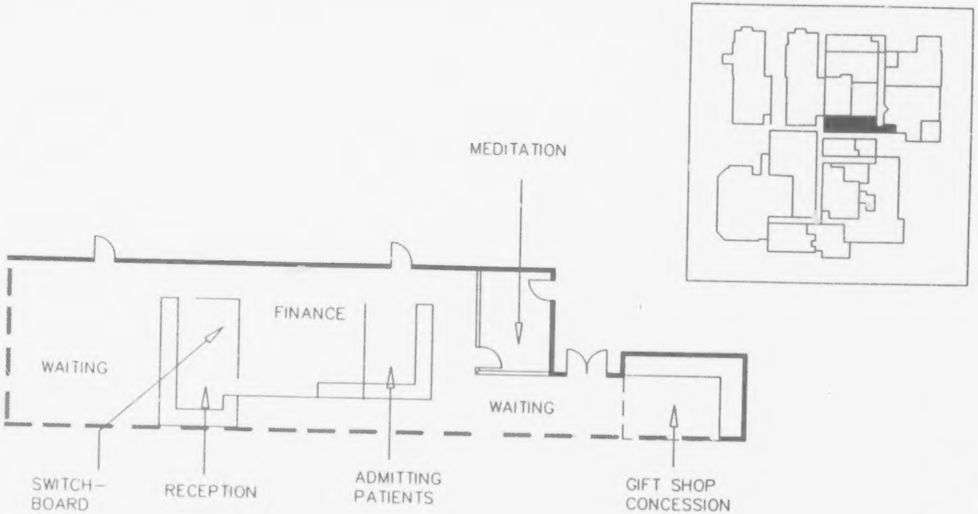
Expected Lobby Occupancy

Inpatient: Projected Daily Inpatient Visitors = 8
Outpatient: Projected Daily Outpatients & Visitor = 91

TOTAL EXPECTED LOBBY OCCUPANCY = 99 Daily

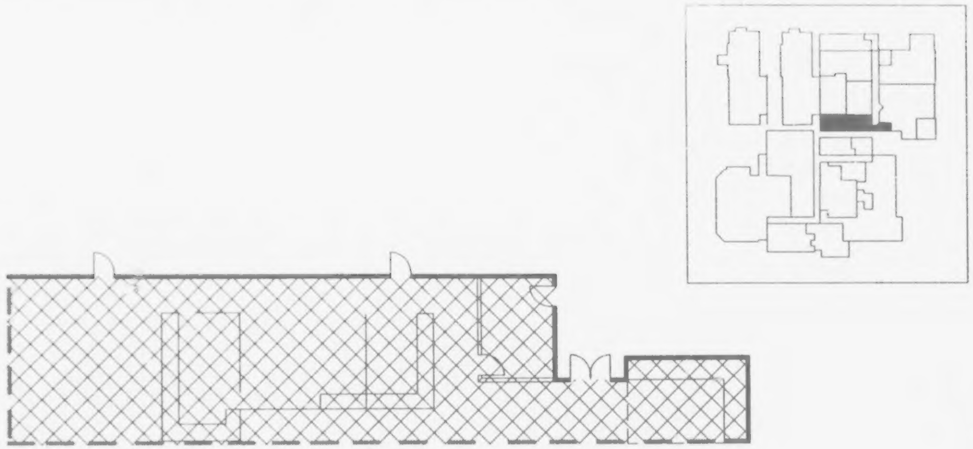
Area Space Summary - Public Facilities

	Area SF	Total SF
Waiting Area		1,540
Sub-Waiting Area - Outpatient Clinic		
Sub-Waiting Area - Community		
Sub-Waiting Area - Dental		
Sub-Waiting Area - Lab & Radiology		
Sub-Waiting Area - P.T. & R.T.		
Information/Switchboard	1 @ 80	80
Public Toilet, Male 3 W.C. + 4 Lav. + 1 U	1 @ 120	120
Public Toilet, Female 4 W.C. + 4 Lav.	1 @ 120	120
Consultation/Spiritual Room	1 @ 120	120
Concession	1 @ 120	120
Gift Shop	1 @ 100	100
TOTAL NSF		2,200


MEDITATION
WAITING
FINANCE
WAITING
SWITCH-
BOARD
RECEPTION
ADMITTING
PATIENTS
GIFT SHOP
CONCESSION
OTHER
DEPARTMENTS
0 5' 10' 25'

PUBLIC FACILITIES

FLOOR PLAN DIAGRAM



▨ EXISTING

▩ NEW CONSTRUCTION

☐ REMODELED

☐ OTHER DEPARTMENTS

PUBLIC FACILITIES

FLOOR PLAN DIAGRAM

CONSTRUCTION STATUS

CENTRAL STERILE AND REPROCESSING

The Central Sterile and Reprocessing Department is responsible for the decontamination, cleaning, sorting, wrapping, and sterilization of reprocessable items used in the hospital.

The primary workload of the department is generated by the Delivery Suite and the Surgical Suite. All items in the suites that may be reused are processed and sterilized prior to return to the suite. Other departments in the hospital generate items such as instrument sets which must also be cleaned and sterilized prior to reuse.

The Central Sterile and Reprocessing Department receives all soiled items in the decontamination area. This area is considered contaminated, and personnel working in the area do not move to other areas of the department. The soiled items are cleaned of any gross materials by means of soaking, detergent/disinfectant washing and ultrasonic cleaning.

In the Workroom the items are sorted and stored if not needed immediately. Instrument packs are sorted, double wrapped, terminally sterilized, and placed in the Sterile Storage Area for future use.

Surgical linen packed in the clean linen and pack preparation room are taken to the sterilizers in the Sterilization Room, held in the Sterile Room, and then taken to the Sterile Storage Area.

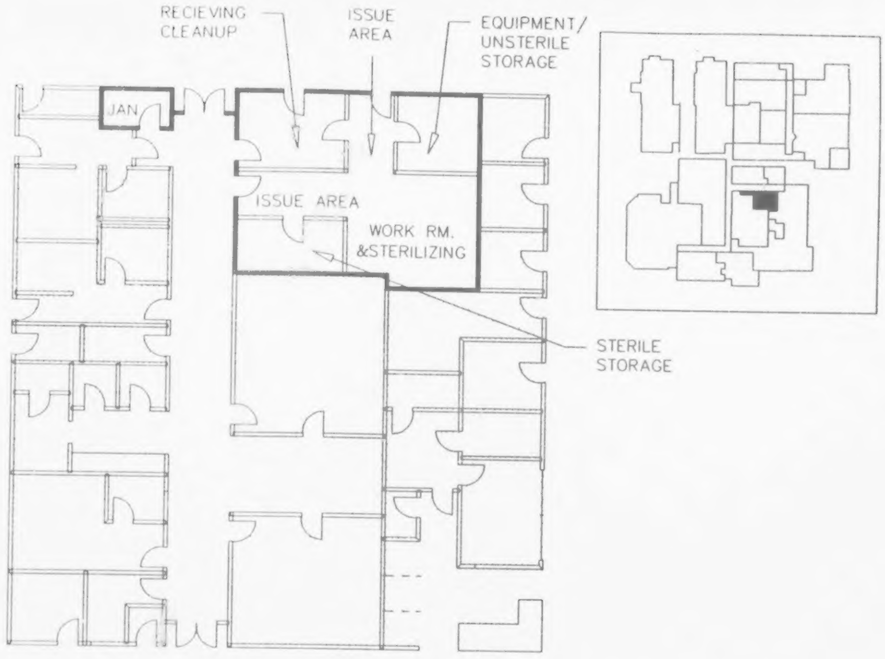
Case carts for Delivery and Surgery, and supply carts for other departments, are drawn from Sterile Storage and issued on either a par level or demand basis.

Program Assumptions and Determinants

Necessary Data	1990	1995	2000
Projected Inpatient Days	3953	4390	5059

Area Space Summary - Central Sterile

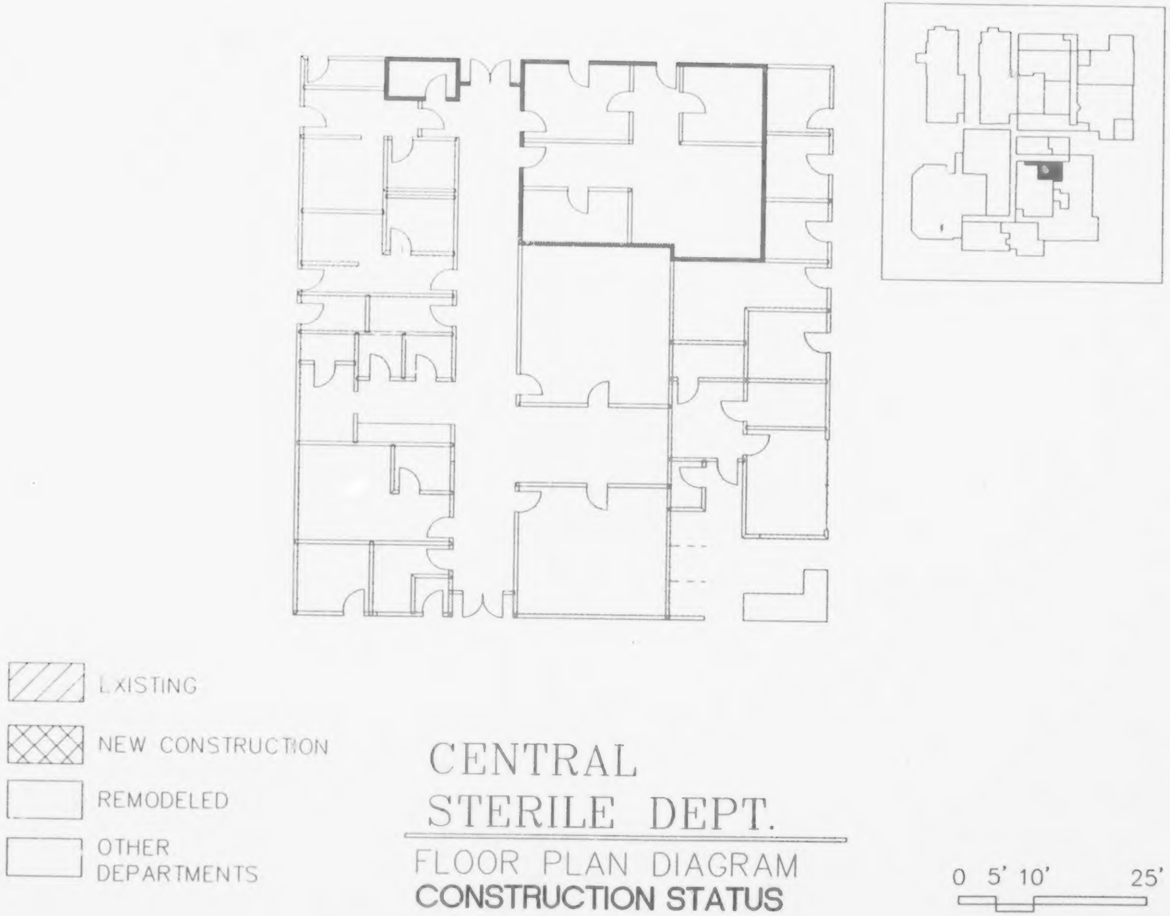
	Area S.F.	Total S.F.
Decontamination Area Cart Washing	1 @ 140	140
Equipment & Clean Storage	1 @ 100	100
Workroom & Sterilizing Clean Linen & Pack Preparation	1 @ 250	250
Sterile Storage	1 @ 150	150
Issue Area/Cart Hold	1 @ 50	50
Janitor Closet	1 @ 40	40
TOTAL N.S.F.		730


RECIEVING
CLEANUP
ISSUE
AREA
EQUIPMENT/
UNSTERILE
STORAGE
JAN
ISSUE AREA
WORK RM.
&STERILIZING
STERILE
STORAGE

CENTRAL STERILE DEPT.

FLOOR PLAN DIAGRAM

OTHER
DEPARTMENTS
0 5' 10' 25'


EXISTING
NEW CONSTRUCTION
REMODELED
OTHER DEPARTMENTS
0 5' 10' 25'

CENTRAL
STERILE DEPT.

FLOOR PLAN DIAGRAM
CONSTRUCTION STATUS

CENTRAL STORES

Central Stores provides materiel supplies to the entire hospital complex. It should be located near the loading dock. Security and inventory control should be a consideration in design. Some of the Central Stores spaces will be located in the existing central warehouse off of the hospital block as noted on the Area Space Summary.

The Central Stores Department is responsible for procurement, receiving, inventory control, bulk storage, and dispensing of medical (excluding medications) and non-medical supplies used in the facility.

The Department determines the appropriate supply level for the facility based on the availability of each supply item, ordering time, and expected use rate. The Department maintains an inventory of all items stored and prepares procurement documents to reorder needed supplies when they are required.

As supplies arrive at the facility, the Department checks them in against procurement documents and puts the supplies into stock. Following receipt of supplies, payment authorizations are released from the Department.

Program Assumptions

	1990	1995	2000
Projected Inpatient Days	3,953	4,390	5,059
Projected Outpatient Visits	17,745	19,706	22,710
Projected Annual Stock Turnover (Alaska Remote with Central Warehouse)			2

Projected Annual Storage Area

.280 Inpatient Storage Area	1,416
.15 Outpatient Storage Area	3,407
TOTAL PROJECTED ANNUAL STORAGE	4,823

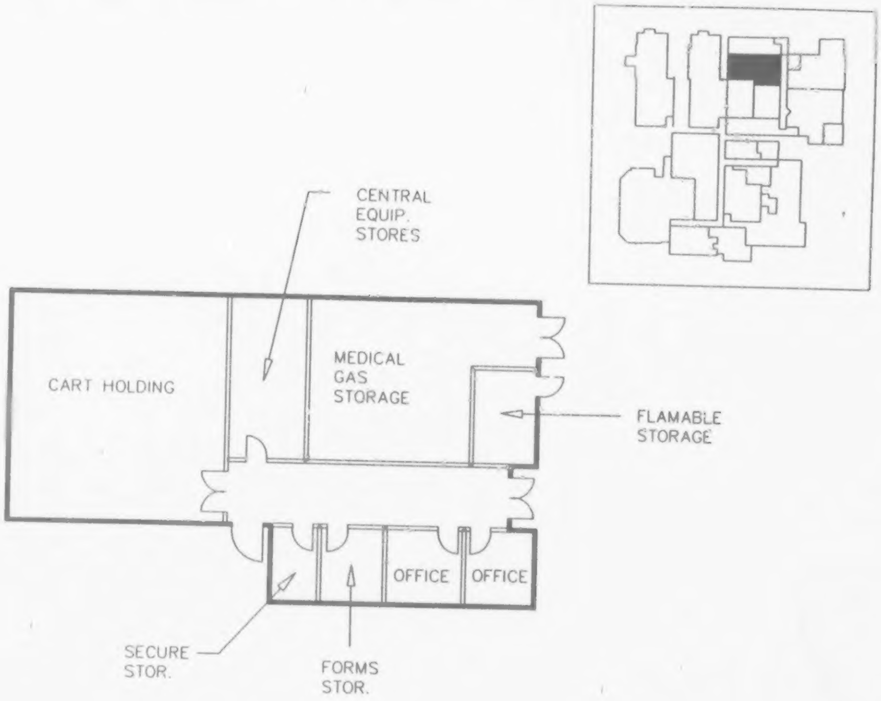
Staff Requirements

	Number
Warehouseman	
Supply Officer	
Supply and Property Clerk	
TOTAL	5

Area Space Summary - Central Stores

	Location	Area SF	Total SF
Receiving/Issue Area	*Warehouse	(1 @ 100)	(100)
Bulk Stores	*Warehouse	(1 @ 1,800)	(1,800)
Cart Holding and Dispatch	Hospital	1 @ 750	750
Central Equipment Stores	Hospital	1 @ 200	200
Village Supply Holding	*Warehouse		(1,000)
Form Stores	Hospital	1 @ 100	100
Secured Storage	Hospital	1 @ 40	40
Flammable Storage	Hospital		100
Medical Gas Storage	Hospital		500
Office - Purchasing	Hospital	1 @ 100	100
Office - Clerk	Hospital	1 @ 80	80
Dead Files Storage	*Warehouse		(500)
Rental Equipment Holding	*Warehouse		(520)
Vehicle Storage (Van, Flat Bed w/Hyd, Pick-up)	*Warehouse	3 @ 240	(720)
TOTAL NSF (Phase I Construction Only)			1,870

* Existing Central Warehouse (4,640 SF)

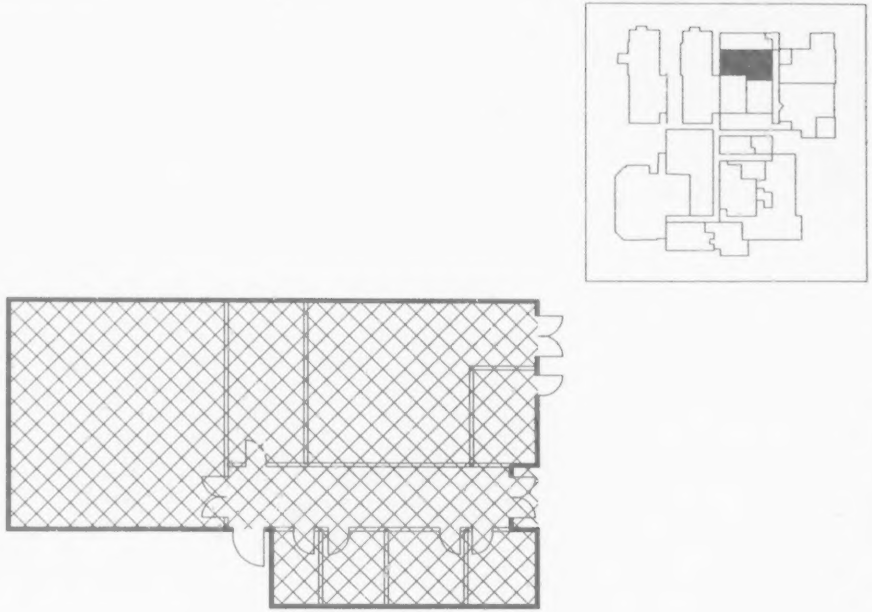

CENTRAL
EQUIP.
STORES
CART HOLDING
MEDICAL
GAS
STORAGE
FLAMABLE
STORAGE
OFFICE
OFFICE
SECURE
STOR.
FORMS
STOR.

CENTRAL STORES DEPT.

FLOOR PLAN DIAGRAM

OTHER DEPARTMENTS

0 5' 10' 25'



▨ EXISTING

▩ NEW CONSTRUCTION

☐ REMODELED

☐ OTHER DEPARTMENTS

CENTRAL STORES DEPT.

FLOOR PLAN DIAGRAM
CONSTRUCTION STATUS

0 5' 10' 25'

DIETETICS

The Dietetics Service is responsible for a comprehensive nutrition program including storage, preparation, service of food, and diet formulation and nutrition counseling for inpatient and outpatient clinics. The Dietetics Service consists of six functional areas.

Food and Non-Food Storage: Normally a 30-day supply of dry food and supplies is stored in the department storeroom. Perishable items are ordered and delivered as required throughout the month. Space is allocated for refrigerated and frozen storage. Additional storage is required for yearly barge shipments of food and supplies.

Food Preparation: Food is prepared in accordance with preplanned cycle menus approved by a registered dietician, and recognized by the American Dietetic Association.

Patient Tray Service: Meals are served either as individual trays delivered to the patient area or to ambulatory inpatients in the cafeteria or day room in the-nursing unit.

Cafeteria Food Service: Meals for ambulatory inpatients and authorized staff are served in the cafeteria. Public use of the cafeteria services will be provided as an option to be implemented at the direction of the hospital administration.

Sanitation: Dishwashing, potwashing, cart washing, and clean dish storage are essential to the department's functions.

Offices: The department's planning, management, and nutrition consultation is performed in the offices.

NSHC08/116

Native Foods: Native residents in long-term care will be served fresh game, and fish according to sanitation guidelines established by the State of Alaska.

Program Assumptions and Determinants

	1990	1995	2000
Projected Number of Inpatient Days	3,953	4,390	5,059
Current Patient Rations*			3,145
Current Inpatient Days*			3,145

Dietary Ration *Factors

ORB

Current IHS Factor 111.31

Dietary Ration *Projections

	1990	1995	2000	
Inpatient Rations*	3,953	4,390	5,059	= 3,953 - 5,059
Other Rations L.T.C.*	4,927	4,927	4,927	= 6,433 - 8,223
Donated	3,202	3,556	4,098	=15,313 -18,219
Cafeteria	3,231	3,588	4,135	
TOTAL RATIONS	15,313	16,461	18,219	

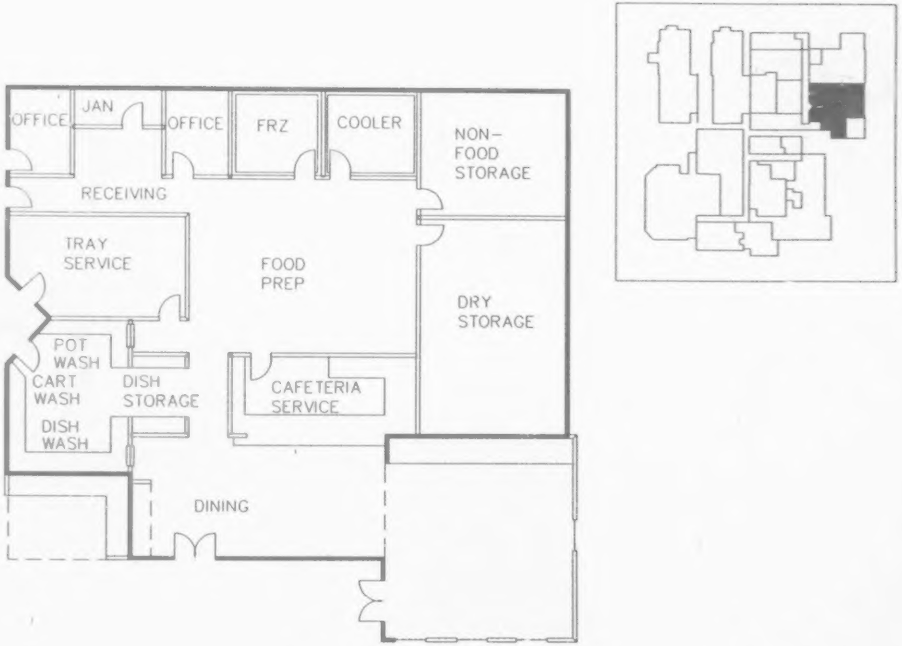
Staffing Requirements

	Number
Dietician	1
Food Service Supervisor (Dietetic Assistant	1
Cook	2.5
Food Service Worker	3
TOTAL STAFF	7.5

* A "ration" is the IHS term for a patient's daily dietary allowance. It includes three meals plus nourishments per day.

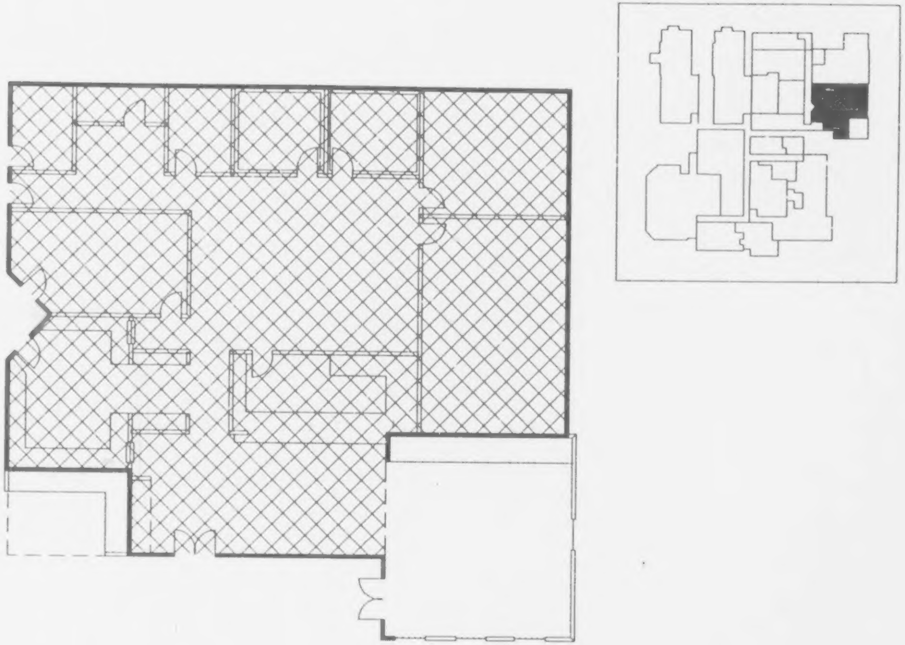
Area Space Summary - Dietetics

	Area SF	1990/95 Total SF
Receiving Area	1 @ 100	100
Refrigerated and Frozen Storage	1 @ 280	280
Dry Food Storage Alaska Factor=3	3 @ 150	450
Non-Food Storage Alaska Factor=3	3 @ 100	300
Food Processing and Preparation	1 @ 500	500
Pot Washing	1 @ 60	60
Patient Tray Service	1 @ 300	300
Cafeteria Food Service	1 @ 150	150
Dining Room	1 @ 350	350
Dishwashing	1 @ 120	120
Dish Collection and Storage	1 @ 40	40
Cart Washing	0 @ 0	0
Janitor Closet	1 @ 60	60
Offices - Dietician; Food Services Supervisor	2 @ 80	160
TOTAL NSF		2,870


OFFICE
JAN
OFFICE
FRZ
COOLER
NON-FOOD STORAGE
RECEIVING
TRAY SERVICE
FOOD PREP
DRY STORAGE
POT WASH
CART WASH
DISH STORAGE
CAFETERIA SERVICE
DISH WASH
DINING
OTHER DEPARTMENTS
0 5' 10' 25'

DIETETICS

FLOOR PLAN DIAGRAM



▨ EXISTING

▩ NEW CONSTRUCTION

☐ REMODELED

☐ OTHER DEPARTMENTS

DIETETICS

FLOOR PLAN DIAGRAM

CONSTRUCTION STATUS

HOUSEKEEPING AND LINEN

The Linen Department is responsible for the collection and processing of soiled linen, clean linen processing, and repair and distribution. Laundry services are provided to the Hospital, the Clinics, Alcohol Rehabilitation, and the Eldercare.

Community Departments located outside the hospital facility, the maternal home, community mental health, chronically mentally ill residential program, and boarding home currently have independent laundry services.

Soiled linen is collected from each department, and taken to the Soiled Linen Room for processing by the laundry. Linen processed by the laundry is sorted, inspected, and folded. Linen requiring repair is sent to the sewing room and is returned to service after repair and cleaning. Surgical linen is sorted and prepared into packs and sent to the Central Sterile and Reprocessing Department for sterilization.

After sorting and folding, white linen is used either to replenish storage shelves or stock linen supply carts. Supply carts are exchanged daily with carts held in each department requiring linen.

Housekeeping is responsible for routine facility cleaning. Janitor closets distributed throughout the facility are placed to assist personnel as mini-supply depots with basic cleaning supplies and a mop sink. The closet is also provided for hospital staff use in urgent clean-up situations. The central housekeeping storage area is for supply storage and cart marshalling.

Program Assumptions and Determinants

Projected Number of Inpatient Beds = 25
Projected Number of Inpatient Days = 5,059
Projected Number of Outpatient Visits = 22,710

Estimated Service Index

Projected Number of Inpatient Beds x 1.1 = 27.5
Projected Number of Outpatient Visits x 0.0005 = 2.5
TOTAL ESTIMATED SERVICE INDEX 30.0

Projected Linen Requirements

Projected Inpatient Linen Requirements 5059 x 13 = 65,767
Projected Outpatient Linen Requirements 2271 x 8 = 18,168
TOTAL PROJECTED LINEN REQUIREMENTS (lbs.) 83,935

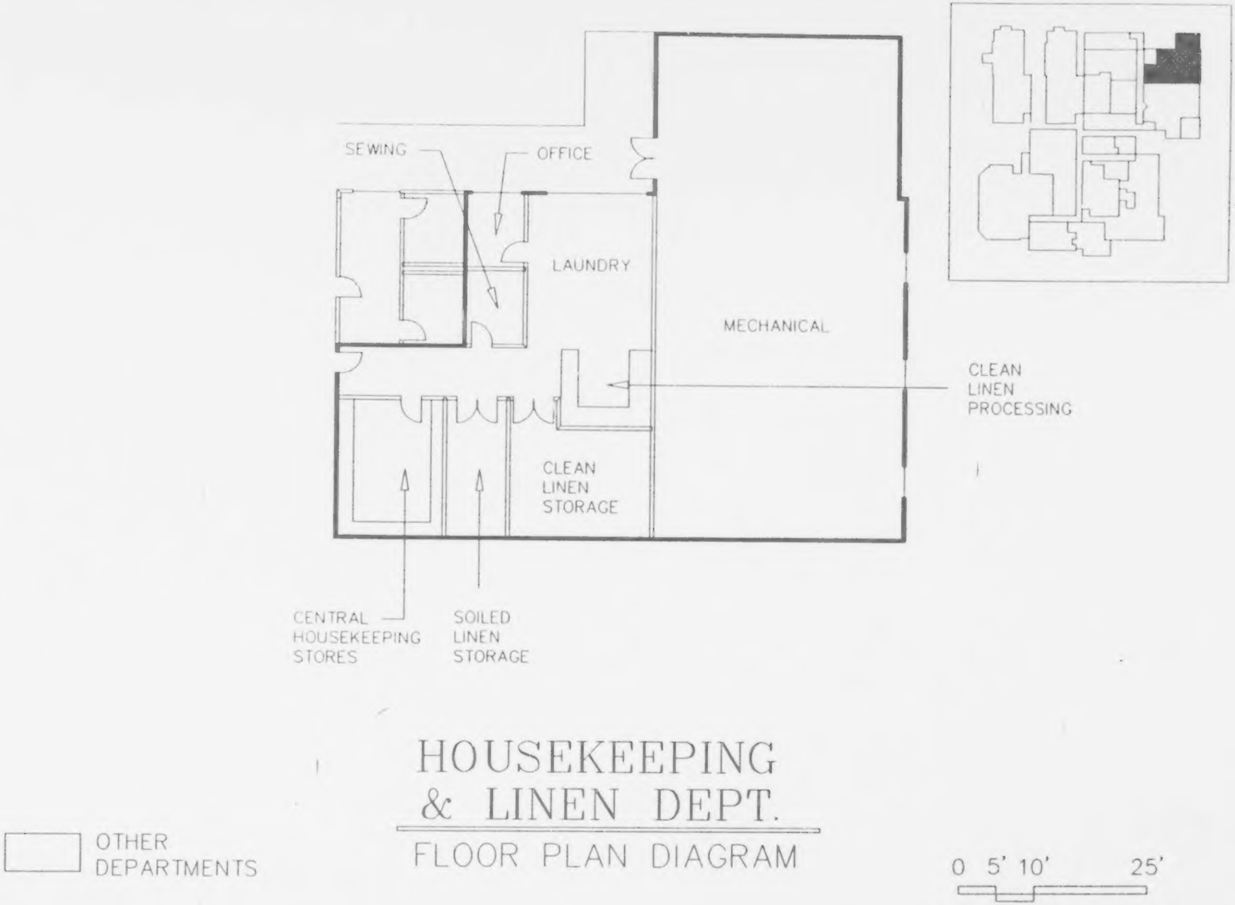
+ Alcohol	12	24
+ Chronically	12	16
+ LTC	15	30
	39	70 Beds outside of hospital

3 to 9 lbs. of linen per day
For 70 beds x 365 x 3 lbs. = 76,650 lbs. annually
For 70 beds x 365 x 6.5 lbs. = 116,075 lbs. annually

Use 150,000 - 250,000 range capacity

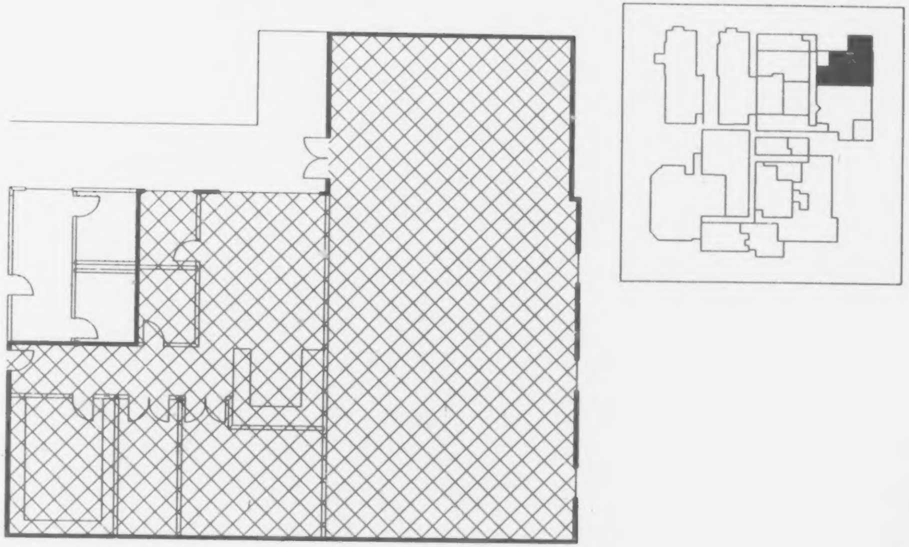
Area Space Summary - Housekeeping and Linen

	Area SF	Total SF
Soiled Linen Storage	1 @ 120	120
Laundry	1 @ 270	270
Clean Linen Processing	1 @ 200	200
Sewing	1 @ 100	100
Clean Linen Storage	1 @ 175	175
Central Housekeeping Stores	1 @ 250	250
Office, Open Plan	1 @ 80	80
TOTAL NSF		1,195


SEWING
OFFICE
LAUNDRY
MECHANICAL
CLEAN LINEN PROCESSING
CLEAN LINEN STORAGE
CENTRAL HOUSEKEEPING STORES
SOILED LINEN STORAGE
OTHER DEPARTMENTS
0 5' 10' 25'

HOUSEKEEPING & LINEN DEPT.

FLOOR PLAN DIAGRAM



▨ EXISTING

▩ NEW CONSTRUCTION

☐ REMODELED

☐ OTHER DEPARTMENTS

HOUSEKEEPING & LINEN DEPT.

FLOOR PLAN DIAGRAM

CONSTRUCTION STATUS

0 5' 10' 25'

MAINTENANCE

The Maintenance Department is responsible for maintenance and repair of the hospital long-term care, the warehouse, the CHS Building and other NSHC facilities. On a continuing basis, the personnel handle maintenance problems as they arise and perform routine preventive maintenance. The department also responds to requests for repair or replacement of equipment or furniture. In addition, the department is responsible for daily grounds maintenance such as snow removal, which in Nome can be an enormous task.

The department requires shop space to perform carpentry, plumbing, vehicle mechanics, electrical, painting, and equipment repair. Storage space is required for equipment and materials.

Maintenance facilities are best located adjacent to the facility power plant or building system monitoring room with access from the shop to the loading dock.

Program Assumptions and Determinants

Projected Number of Inpatient Beds = 25
Projected Number of Outpatient Visits = 8686

Estimated Service Index

Projected Number of Inpatient Beds x 1.1 = 275
Projected Number of Outpatient Visits x 0.0005 = 15.9

Gross Area of Other Buildings Maintained

2000

TOTAL ESTIMATED SERVICE INDEX 43.4*

Assume 31-60 range to allow for other buildings maintained.

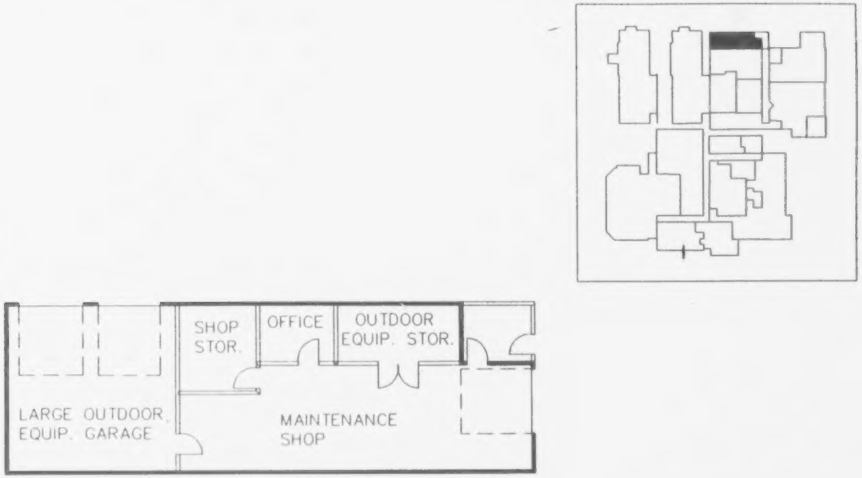
NSHC08/118

Staff Requirements

	Current	Proposed
Supervisor	1	1
General Facilities Repairman	3	3
Biomedical Engineer		1
TOTAL STAFF	4	5

Area Space Summary - Maintenance

	Area SF	Total SF
Maintenance Shop	1 @ 550	550
Shop Storage	1 @ 120	120
Outdoor Equipment Storage	1 @ 150	150
Office - Unit Supervisor	1 @ 100	100
Large Outdoor Equipment Garage	2 @ 250	500
TOTAL NSF		1,420

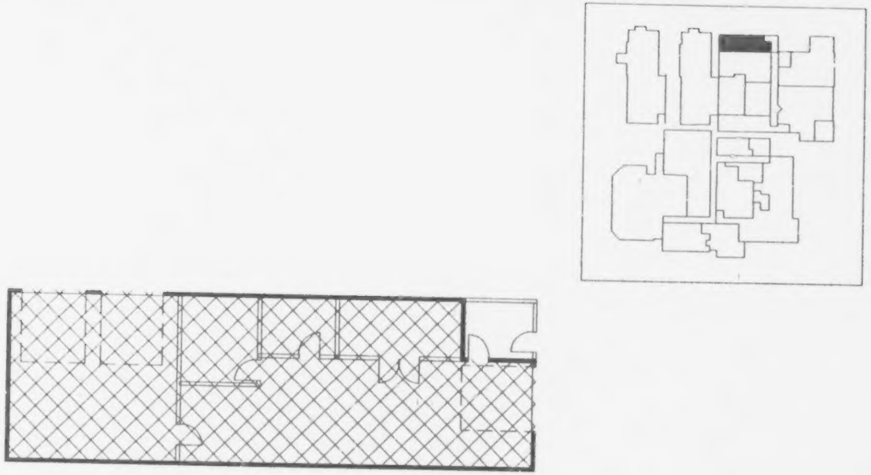

SHOP STOR.
OFFICE
OUTDOOR EQUIP. STOR.
LARGE OUTDOOR EQUIP. GARAGE
MAINTENANCE SHOP

MAINTENANCE

FLOOR PLAN DIAGRAM

▭ OTHER DEPARTMENTS

0 5' 10' 25'



▨ EXISTING

▩ NEW CONSTRUCTION

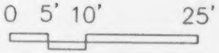
☐ REMODELED

☐ OTHER DEPARTMENTS

MAINTENANCE

FLOOR PLAN DIAGRAM

CONSTRUCTION STATUS



BUILDING SERVICES

The Building Service areas are the Building Systems Monitoring Room and Loading Dock.

The Building System Monitoring Room is the control room for the heating and air conditioning system, fire signal monitors, security monitors, conveying device monitors, and communication system monitors. This room is operated 24 hours a day and is the control center for the facility.

The Loading Dock is located adjacent to the Service Entry/Exit. It must serve housekeeping, dietetics, central stores, and maintenance departments.

Program Assumptions and Determinants

Projected Number of Inpatient Beds	25
Projected Number of Outpatient Visits	8686

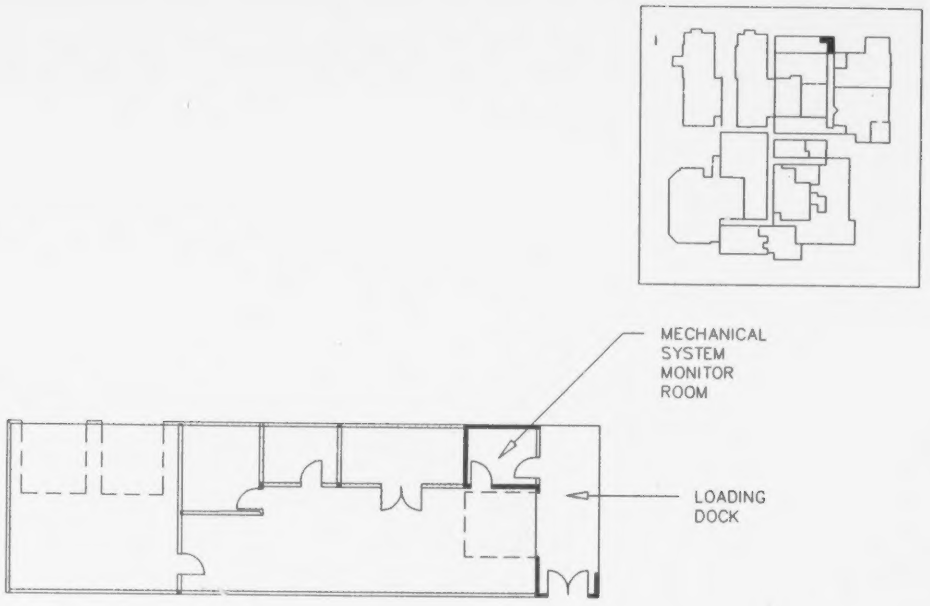
Estimated Service Index

Projected Number of Inpatient Beds x 1.1	27.5
Projected Number of Outpatient Visits x .0005	15.9
TOTAL ESTIMATED SERVICE INDEX	43.4

Area Space Summary - Building Services

	Location	Area SF	Total SF
Loading Dock	Hospital	1 @ 60	60
Mechanical System Monitor Room	Hospital	1 @ 100	100
Two Vehicle Garage	*Warehouse	1 @ 500	500
TOTAL NSF (Phase I Construction Only)			160

* Existing Central Warehouse

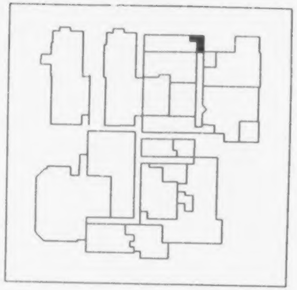

MECHANICAL
SYSTEM
MONITOR
ROOM
LOADING
DOCK

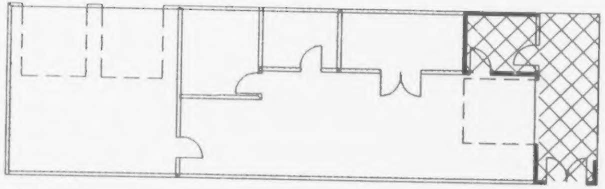
BUILDING SERVICES DEPT.

FLOOR PLAN DIAGRAM

▭ OTHER DEPARTMENTS

0 5' 10' 25'





▨ EXISTING

▩ NEW CONSTRUCTION

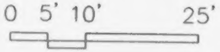
☐ REMODELED

☐ OTHER DEPARTMENTS

BUILDING SERVICES DEPT.

FLOOR PLAN DIAGRAM

CONSTRUCTION STATUS



VIII. ARCHITECTURAL

BUILDING TECHNOLOGIES AND ASSEMBLIES

1. Exterior Finishes

   a. Walls: Insulated metal panels over insulated stud framed walls.
   (R = 30)

   b. Roofs: Steel panel - Sloped Roof.
   Inverted roof membrane assembly (IRMA) - Flat Roofs.
   (R = 48)

   c. Floors: Two layer plywood on truss Joints with 12" Batt insulation.
   GWB and plywood attached to bottom chord of truss.
   (R = 36)

   d. Handicapped ramps, decks: Expanded metal grate.

2. Interior Finishes (by department)

   a. Acute Care Nursing

      (1) Floors: Sheet vinyl or vinyl tile
      Ceramic tile

      (2) Walls: Painted gypsum wallboard
      Ceramic tile/vinyl wall covering

      (3) Ceiling: Acoustical ceiling tiles/panels

   b. Nursery

      (1) Floors: Sheet Vinyl
      (2) Walls: Painted gypsum wallboard
      (3) Ceiling: Acoustical ceiling panels/tiles

c. Delivery/Surgery

(1) Floors: Sheet vinyl
Ceramic tile

(2) Walls: Painted gypsum wallboard
Ceramic tile/vinyl wall cover

(3) Ceiling: Acoustical ceiling panels/tiles
Painted, water resistant wallboard

d. Laboratory/Pathology

(1) Floors: Sheet vinyl
(2) Walls: Vinyl wall covering
(3) Ceiling: Acoustical ceiling tile/panels

e. Radiology

(1) Floors: Sheet vinyl or vinyl tile or carpet

(2) Walls: Painted gypsum wallboard over lead lined walls

(3) Ceiling: Painted gypsum wallboard
Acoustical ceiling panels/tiles

f. Emergency Department

(1) Floors: Sheet vinyl

(2) Walls: Painted gypsum wallboard;
Vinyl wall covering (selected walls)

(3) Ceiling: Acoustical ceiling tiles/panels

g. Outpatient\Department

(1) Floors: Sheet vinyl/vinyl tile or carpet
(2) Walls: Painted gypsum wallboard
(3) Ceiling: Acoustical ceiling panels/tiles

h. Physical Therapy

(1) Floors: High grade carpet
Ceramic tile
Sheet vinyl

(2) Walls: Ceramic tile/vinyl wall covering
Painted gypsum wallboard

(3) Ceiling: Acoustical ceiling panels

i. Respiratory Therapy

(1) Floors: Sheet vinyl
(2) Walls: Painted gypsum wallboard
(3) Ceiling: Acoustical ceiling panels/tiles

j. Health Records

(1) Floors: Sheet vinyl or vinyl tile
(2) Walls: Painted gypsum wallboard
(3) Ceiling: Acoustical ceiling tiles/panels

k. Employee Facilities

(1) Floors: Carpet
Ceramic tile

(2) Walls: Painted gypsum wallboard
Ceramic tile/vinyl wall covering

(3) Ceiling: Acoustical ceiling panels/tiles
Painted, water resistant wallboard

l. Consulting/Training

(1) Floors: Sheet vinyl or vinyl tile
(2) Walls: Painted gypsum wallboard
(3) Ceiling: Acoustical ceiling panels/tiles

m. Public Facilities

(1) Floors: High grade carpet;
Ceramic tile (toilet rooms)

(2) Walls: Painted gypsum wallboard (standard)
Vinyl wall covering (selected walls)

(3) Ceiling: Painted gypsum wallboard
Acoustical ceiling tiles/panels

n. Central Sterile

(1) Floors: Sheet vinyl
(2) Walls: Painted gypsum wallboard
(3) Ceiling: Painted gypsum wallboard

o. Central Stores

(1) Floors: Sheet vinyl or vinyl tile
(2) Walls: Painted gypsum wallboard
(3) Ceiling: Acoustical ceiling panels/tiles

p. Dietetics

(1) Floors: High grade carpet
Sheet vinyl
Quarry tile

(2) Walls: Painted gypsum wallboard
Vinyl wallcovering (selected walls)

(3) Ceiling: Painted gypsum wallboard
Acoustical ceiling tile

q. Housekeeping and Linen

(1) Floors: Sheet vinyl
(2) Walls: Painted gypsum wallboard
(3) Ceiling: Acoustical ceiling tile/panels

r. Maintenance

(1) Floors: Sheet vinyl
(2) Walls: Painted gypsum wallboard
(3) Ceiling: Painted gypsum wallboard

s. Building Services

(1) Floors: Hardened concrete

(2) Walls: Water resistant gypsum wallboard - painted

(3) Ceiling: Exposed structure
Painted gypsum wallboard

3. Interior Finishes (General)

a. Vestibules

(1) Floors: Rubber tire mat

(2) Walls: Painted gypsum board

(3) Ceiling: Suspended acoustical ceiling
Painted gypsum board

b. Corridors

(1) Floors: High grade carpet
Sheet vinyl

(2) Walls: Gypsum board with vinyl wall covering

(3) Ceiling: Suspended acoustical ceiling

4. Doors

   a. Interior (2 hour occupancy separation & area separation): Hollow metal, not less than 1-1/2 hour rating.

   b. Interior (corridor doors): 20 minute rated hollow metal doors with vision panels where required. Plastic laminate finish.

   c. Interior (all others): Generally non-rated hollow metal doors with vision panels where required. Plastic laminate finish.

   d. Exterior (entrance): Metal insulated door with safety glazing.

   e. Exterior overhead garage): Metal insulated door with electric opener.

5. Cabinets

   a. Cabinetry in all areas shall be manufactured units with a sanitary surface. Modular units where appropriate.

   b. Custom cabinets and counters at major reception areas, nurses stations.

6. Windows

   a. Interior: Wired glass in metal frames.

   b. Exterior: Double glazed clear glass set in weather protective aluminum frames with thermal breaks.

c. Skylights: Clear insulating glass set in aluminum frames.

7. Window Treatment

Window treatment shall be fabric pleated shades or metal micro blinds. Blackout shades shall be provided in rooms requiring total darkness during Nome's summer nights.

8. Hospital Equipment

Special hospital equipment will be provided as required to promote an efficient, functional facility. Existing equipment will be evaluated in terms of cost efficiency and functional obsolescence on a department by department basis before determining if it should be replaced.

IX. CIVIL/LANDSCAPE

PARKING

Parking on the hospital block will be limited due to lack of available space. Short term "customer" parking (primarily Eldercare related) and some parking for NSHC vehicles will be provided at the northwest corner of the site. Long term visitor and staff parking will be provided off site on the adjacent block to the east. Some on site parking should be provided for snow machines and ATVs.

SERVICE

A service/delivery entry will be provided at the northeast corner of the site. A covered loading dock and ramp will be provided in this location.

BUILDING ACCESS

The primary building access for visitors will be from the east entrance with a secondary entrance from the west. The east entrance is served by a vehicular passenger drop off area surrounded by a covered walk way leading to the hospital entrance. A secondary building emergency access will be provided at the south end of the site at the same location as the current emergency entrance. The new Eldercare is served by its own entrance on the west side of the site. Staff entrances are through the service entrance and existing west entrance to the 48 building as well as the main east/west entrances.Covered handicap access will be provided at all building entrances with the exception of the 48 building entrance and the service entrance.

LANDSCAPE

To enhance the building and site, landscaping will be provided. Plants and grasses indigenous to Nome will be used. Small featured areas at the main building entrance will be landscaped with annuals that will adapt to Nome's summer climate.

SOILS

Refer to soils report for Nome Eldercare dated May 22, 1987 by Duane Miller and Associates, Soils Engineer.

UTILITIES

City water and sewer are available on Fifth Avenue and on Division Street. City electric power is available with a main transformer located at the northeast corner of the hospital block. Telephone service is available at the site.

X. STRUCTURAL

GENERAL

The Scope of Work under this section is to provide the structural design for the building included under this contract, complying with all applicable State and local building and fire codes.

STANDARDS

All materials and methods shall conform to the latest rules, regulations, and/or specifications of the following authorities:

American Society for Testing Materials (ASTM)
American Concrete Institute (ACI)
American Institute of Steel Construction (AISC)
American Welding Society (AWS)
National Bond of Fire Underwriters (NBFU)
Uniform Building Code, 1985 (amended by local code) (UBC)

FOUNDATION

Several foundation options have been explored for use on the hospital. One option was to provide a shallow footing foundation design with a slab on grade. While this foundation system is feasible, it does not maintain the required blow-through space under the existing 1977 hospital. With that in mind, the second option, a pile foundation, appears more desirable.

A pile foundation will allow the structure to be supported above grade, thus maintaining the blow-through space beneath the Eldercare and the 1977 hospital wing. The ground surface under the building should be sloped to drain towards the street to eliminate water ponding under the building.

Driven H-piles (similar to those used on the 1988 Eldercare wing) will be used for foundation support of the hospital. The pile should be driven to refusal on the bedrock underlying the site. The H-pile should be a compact section to facilitate easier installation of the pile and to reduce damage to the pile.

FRAMING SYSTEM

The steel piles or perimeter foundation will support steel wide flange beams with wooden nailers on the top flange. The steel wide flange beams will support a wooden floor system of pre-engineered wood trusses and a double layer 1-1/8 inch plywood deck. The roof framing system will be similar to the floor framing system; steel wide flange beams with nailers, pre-engineered wood roof trusses with a 3/4 inch plywood roof deck. Lateral loads will be resisted with a steel braced frame system. These frames will be located out-of-sight, generally in exterior walls.

DESIGN LIVE LOADS

1.	Roof, Snow Load:	40 psf + drifts
2.	Floor:	
	Corridors, Stairways, Conference Rooms	100 psf
	Office Area	50 psf
	Patient Rooms	40 psf
	Mechanical Room	125 psf
3.	Wind:	100 mph basic
4.	Seismic:	Zone 1

XI. MECHANICAL

GENERAL

The main sources for heat generation for the Norton Sound Regional Hospital are steam boilers dating back to original construction. There are heat exchangers that convert the steam to a glycol system and yet some steam coils and radiators are still in use. This type of evolution is common to all mechanical systems. For example, there was more than one service for domestic water and sewer. As the facility developed, the most economical method for expansion was utilized. In the Master Plan, the maximum consolidation will be attempted to centralize and reduce maintenance and operations costs.

WATER

The existing domestic water is provided via a 3" tap and meter located in a utility room in the Outpatient area of the 1978 building. The sprinkler service is a 6" dia. main. The limit for a single zone sprinkler service is 52,000 sf. Since the overall building will be 78,000 sf, the 8" dia. main insulated arctic pipe is adequate for the entire facility. However, a separate 4" zone will be required to accommodate the area beyond the limit for each rise. Simultaneously, the water service tap will need to be upgraded to 4" dia. and a pipe extended to the new Dietetics area in Phase IIa. The existing recirculation line to prevent the water service from freezing is adequate. A separate 2 ½" main extends to the 1948 construction.

SEWER

A unit fixture count was made for the existing plumbing during the Eldercare Addition in 1987. The 6" dia. service (arctic pipe) is fully loaded. Due to the large number of institutional fixtures, the Hospital will need a 8" discharge main. The only feasible design would be to extend a new 4" dia. sewer service (arctic pipe) from Dietetics (Phase IIA) to a location near the Eldercare and provide a new 8" dia. main to service from that point to the manhole at the corner of 5th Avenue and Bering Street.

BOILER PLANT

Under the Master Plan, the boilers will be centralized into one area, incorporated into the complex. The current boiler plant is located in a detached structure.

1. Hydronic Heating: Some existing air handling units, such as the kitchen, use steam coils to provide heat. There are two main converters and one remote that generate glycol for heating. The final design will rely on hot water boilers to provide hydronic glycol heating for the whole building. Two main boilers with a peak demand capacity of 4,000,000 BTU/hr will be needed. The main header will be 6" dia. with two 4000 GPM circulating pumps.

2. Domestic Hot Water: The kitchen/laundry equipment needs 140 deg. F. water. The rest of the facility uses 125 deg. F. water. By using two interconnected hot water generators, some standby capability will be provided. Since the demands are about equal, 250 gallons of storage and 750,000 BTU/hr firing rate will be necessary. The current storage is higher (500 gallons), but we recommend a reduction for economy by relying on faster recovery rates.

3. Steam Boiler: For process steam, a steam boiler is needed. The main load is humidification to meet HEW dictated comfort conditions in the hospital. The existing humidification load is 750,000 BTU/hr; a boiler of 2,000,000 BTU/hr is being used for this purpose. If any steam kettles are used in the kitchen, they can be serviced along with sterilizers, etc. The sterilizers will be in the Central Sterile and Reprocessing Area.

MEDICAL GASES

The medical oxygen generator dates back to 1977. If more than 2 or 3 years elapse before Phase I is started, a new unit is advisable based on consideration of the economic life of the existing unit. The critical life-safety nature of the medical gas system dictates that full care be taken to keep it functional and reliable. The main distribution system and headers do not need upgrading because not a great enough demand beyond the two additional patient rooms in Phase 1C is envisioned. The new mechanical Room will have to be large enough to accommodate a dedicated area for medical gases. It may be feasible to locate the gas manifold in Central Stores also, depending on space allocation.

KITCHEN EQUIPMENT

As much as practical, the new cooking equipment should be selected to operate on propane or steam. This will save on energy costs. A method for heat recovery from the exhaust hood should be designed - it will have a fast payback. A 180 deg. F booster heater (electric) will be needed for the dishwasher to raise the temperature of the 140 deg. F water for sterilization.

INCINERATOR

A small pathological waste incinerator is essential for the Hospital. It can be located in the mechanical room. The current unit is rated for 50 lb/hr. which is adequate but the unit is twelve years old. Due to consideration of economic life, a new unit is desirable rather than relocating the old one.

LAUNDRY

This new laundry should have a pass-through type washer-extractor which allows loading from one side and unloading from the opposite end. Also, for energy conservation, propane dryers should be installed. It is feasible to use steam but the maintenance costs will be higher. The soiled linen room must be at negative air pressure and the clean linen room at positive air pressure at all times for hygenic reasons. There will be 140 deg. F hot water supplied to the washer-extractor.

VENTILATION

A constant volume ventilation system is needed for the Hospital to ensure that proper air flow and pressure relationships are maintained. All the new ducts will be in the ceiling. Central humidification, using steam, will be provided. Based on energy considerations, a heat exchanger or a run-around loop should be designed to recover heat from the exhaust air.

HEATING

Utilizing glycol as the heating medium, finned-tube radiation will be installed on all exterior walls. In the entries and vestibules, cabinet unit heaters will be used. Under the floor, the soffit will be heated with unit heaters. Hot water radiant ceiling panels, similar to those used in the Eldercare Addition, will be considered as an alternative system for perimeter heating in habitated spaces.

SPRINKLERS

The entire facility has sprinklers for fire protection. All new and remodeled areas will also be provided with sprinklers in accordance with NFPA-13.

PLUMBING

The plumbing will be extended to all new fixtures. In particular, a whirlpool will be added in Physical Therapy. All other hospital fixtures such as bedpan washers, handicapped showers, janitor's sinks will be provided as needed.

NSHC08/209

CONTROLS

A central energy management and control system has been installed in the current Maintenance Office. Not all the equipment in the 1948 wing nor the Eldercare is connected to the ECMS. Under Phase I, all HVAC equipment should be connected to the Johnson Controls ECMS direct digital control panel. The dual benefits will be higher savings and lower maintenance costs. The existing controls are mainly pneumatic utilizing Johnson Controls equipment.

TESTING AND BALANCE

With the completion of the Eldercare Addition in 1988, all systems appear to be functioning properly. The testing and balancing indicates that the facility is operating per the 1977 design. Thus, the Phase I design can proceed to build upon the current as-builts. The new addition in Phase 1A will have a penthouse for air handling equipment similar to the other wings. Special attention will have to be given to the phasing of construction to avoid extended interruption of Hospital operations.

PHASING

At all times it will be necessary to keep the facility operational. Any extended shutdown of life-safety systems will not be allowed. Thus, during design and construction, the new systems will have to be in place before any existing equipment is demolished. Consequently, the Mechanical Support in Phase 1A will be completed prior to demolition of the detached Boiler Plant. There will be need for bypass and isolation valves to allow for proper phasing. In case of temporary shutdowns, permission upon request will only be granted by NSHC Administration.

XII. ELECTRICAL

GENERAL

The Norton Sound Regional Hospital original facility was built in the late 1940's. An addition to the facility was constructed in 1978. Since then, quite a few modifications and additions such as the Eldercare wing and off-site Community Services Building have been added. This has impacted the electrical service. Since new floor gross areas of the order of 28,800 square feet in Phase II (per the Masterplan Study) and 9,500 square feet net increase in Phase III (per the Masterplan Study) are planned, this will significantly impact the electrical loads.

ELECTRICAL SERVICE

The Norton Sound Regional Hospital is served by Nome Joint Utilities with three single phase pole mounted transformers. From the pole, underground feeders enter the building and feed the main switchboard. The main switchboard is a three phase, four wire, 1200 amperer unit, 208Y/120 volts. This switchboard serves the 1978 portion as well as the old 1948 portion of the building. The switchboard is not currently overloaded but has used up all the available spaces for breakers.

Load Analysis

Existing Loads in KWH's = 68,520
(utility meter readings in Dec. 1981)

Average Load in KW = $\frac{68,520}{24 \times 30} = 95$ KW
(24 hrs. operation)

Peak Demand Load = 95 x 1.4 = 133 KW = 166 KVA = 465 Amperes

Measured Maximum Load in Amps = 457 amp (average of 3 phases)
(Reading taken on main switchboard on 2/3/87 at 3 p.m.)

Measured Load in Amperes = 50 amps
(Community Services Building)

Total Measured Load in Amperes = 457 + 50
= 507 amperes
= 146.4 KW
= 183 KVA

So the present total maximum
demand load of the facility = 507 amperes

Demand Load of Eldercare Addition = 40 KVA = 110 amperes

Total existing maximum demand load = 617 amperes

Future additions under Phase II (New Area) = 28,800 sf.

Future additions under Phase III (Estimated
new area from Masterplan Study) = 9,500 sf.
Total 38,300 sf.

Total estimated demand load = 38.3 kw x 7 w/ft.
= 268.1 kw
= 743 amperes

Total future demand = 617 + 743 = 1,360 amperes
Required size of main switchboard = 2,000 amperes

Thus the present 1200 amp switchboard will not be adequate to serve the total needs as per Master Plan. A new 2000A switchboard will be required. This will be installed in the Phase 1A addition. This will also be a good time to clean up some of the existing distribution systems that do not meet code.

NSHC08/209

EMERGENCY AND STANDBY POWER

Presently, the Norton Sound Regional Hospital is served by a 100 kw generator. With the increase of the areas of the hospital, this generator will be inadequate to meet the demands and any expansions thereon. We anticipate that the existing 100 kw. generator will have to be replaced with a new 250 kw generator. Even though the loads such as life safety, critical and mechanical equipment loads are separated, the medical equipment loads are not segregated. These loads, such as X-Ray, air compressors, etc., will be analyzed and separated where needed.

The new generator will be housed in the Phase 1A addition.

CODE UPGRADE

In existing building renovation areas, complete code upgrade of existing electrical installation will be provided per current electrical codes.

WIRE AND CONDUIT

1. Three phase secondary feeders in conduit will feed the new panelboards and existing switchboard.

2. Branch circuit wiring from the panelboards will consist of insulated copper conductors, in conduit, to the various equipment such as lighting, convenience outlets, and motors.

3. Conduit in sizes 1-½ inch or less = EMT, larger than 1-1/2 inch = GRC or IMC indoors; GRC or IMC outdoors or underground; PVC underground for telephone.

LIGHTING

New energy efficient lighting in new additions and renovated areas of the facility will be provided, since the cost of energy in Nome is relatively high.

1. Interior Lighting:

   Lighting for all interior spaces shall be designed per Illuminating Engineering Society (IES) and per US Department of Health, Education and Welfare standards.

   a. Patient Rooms-Acute Care: Wall mounted direct/indirect fluorescent lighting will be used for general illumination for each patient bed. A wall mounted reading light will be provided. Recessed night light will also be provided at 24 inches above finished floor and shall be switched at entrance. Control of general patient light shall be at the bed.

   b. Housekeeping & Linen: Fluorescent lighting fixtures will be provided. Type of fixture will be based upon type of ceiling. 50 fc will be provided.

   c. Dietetics, Consultant Training, Employee Facilities: Fluorescent lighting will be provided in general. Incandescent lighting will be provided in the dining areas and other areas for esthetics purposes. 70 fc illumination will be provided.

   d. Mechanical: Surface mounted fluorescent fixtures will be provided. 30 fc illumination will be provided.

   e. Health Records: Fluorescent lighting will be provided at 70 fc illumination level.

f. Laboratory/Pathology: In general 100 fc of lighting will be provided with fluorescent fixtures. Some task lighting will be provided.

g. Maintenance: Surface mounted fluorescent fixtures will be provided with 70 fc level.

h. Central stores: 50 fc of lighting with fluorescent fixtures will be provided.

2. Exterior Lighting:

High pressure sodium fixtures will be used for exterior security. Most fixtures will be pole mounted and some will be building mounted. Placement will address glare into patient rooms. High pressure sodium lamps are highly energy efficient lamps. Energy efficient ballasts will be used.

MECHANICAL EQUIPMENT

All mechanical motors greater than 1/2 HP will be served with 3-phase, 208 volt. One-half HP and below will be served with 120 volt, single phase.

GROUNDING

All electrical systems such as panelboards, cabinets, conduit system, equipment, and fixtures will be grounded per NEC Code at the time of design. Electric service will be grounded per NEC code. Special grounding will be provided in the acute care patient rooms.

FIRE ALARM SYSTEM

The existing Fire Alarm Panel in the existing facility is old and antiquated and will be replaced with a new panel. There have been false alarms and complaints with the existing system. The zones are at maximum capacity with the recent addition of the Eldercare which is connected to the old panel. New devices will be added for the new addition. Renovation area devices will be replaced if not compatible with the new panel. Existing manual pull stations will be reused. A graphic annunciator will also be provided to facilitate the Fire Department.

Due to the size and complexity of the building, it is essential to rely on a graphic annunciator for faster pinpointing of alarms.

INTERCOM SYSTEMS

A new intercom system will be considered under the new addition and renovation plan to suit the Master Plan of the hospital. The existing amplifier does not have complete capacity and adequate zoning for a modern facility.

NURSE CALL SYSTEM

Existing nurse call system is a Dukane 2000 series. Since new areas do no have any nurse call needs, this system will not be changed. At present time, the system is working properly and no changes are anticipated. Two stations will be extended into the acute care patient rooms.

TELEPHONES

The construction will allow for plug-in jacks. The local telephone utility provides instruments and wiring to the complex.

XIII. CODE ANALYSIS

Occupancy: See Attached Plan A

I-1: Hospitals with non-ambulatory patients accommodating more than five persons.

B-1: Maintenance shop/garage.

B-2: Office areas.

Occupancy Separations Required: See Attached Plan A

2 hours between I-1 and B-2.
4 hours between I-1 and B-1

Construction Type:

Type V - 1 hour.

Allowable Area:

5,200 sq. ft. (Table 5-c) (basic allowable floor area)
+5,200 sq. ft. (506(a)3) (separation on all sides)

10,400 sq. ft. Per Table 5-c
x 3 (506(a)3(c)) (automatic sprinkler system)
31,200 sq. ft.

Allowable Height:

50' or two stories. (Table 5-D)

Actual Height:

34' (maximum)

Actual Area: See Attached Plan B

Area 1 - 5,530 square feet.
Area 2 - 24,668 square feet.
Area 3 - 28,770 square feet.

Total: 58,968 square feet.

Area Separations Provided: See Attached Plan B

Occupant Loads Calculated:

Area 1 - $\frac{5,530 \text{ S.F.}}{80 \text{ S.F.}} = 69$

Area 2 - $\frac{24,668 \text{ S.F.}}{80 \text{ S.F.}} = 308$

Area 3 - $\frac{28,770 \text{ S.F.}}{80 \text{ S.F.}} = 360$

Total: 737 Occupants

Exits Required (Calculated):

* Area 1 - 2 exits required (min.).
* Area 2 - 2 exits required (min.).
* Area 3 - 2 exits required (min.).

* Minimum of two exits other than elevators are required where number of occupants is at least 6, per Table 33A.

Minimum Size of Exits:
(Per UBC Section 3321(b)

"Every exit opening through which patients are transported in wheelchairs, stretchers or beds shall be of sufficient width to permit the ready passage of such equipment but shall have a clear width of not less than 44 inches. There shall be no projections within the 44-inch clear width."

Corridors:
(Per UBC Section 3321(c)

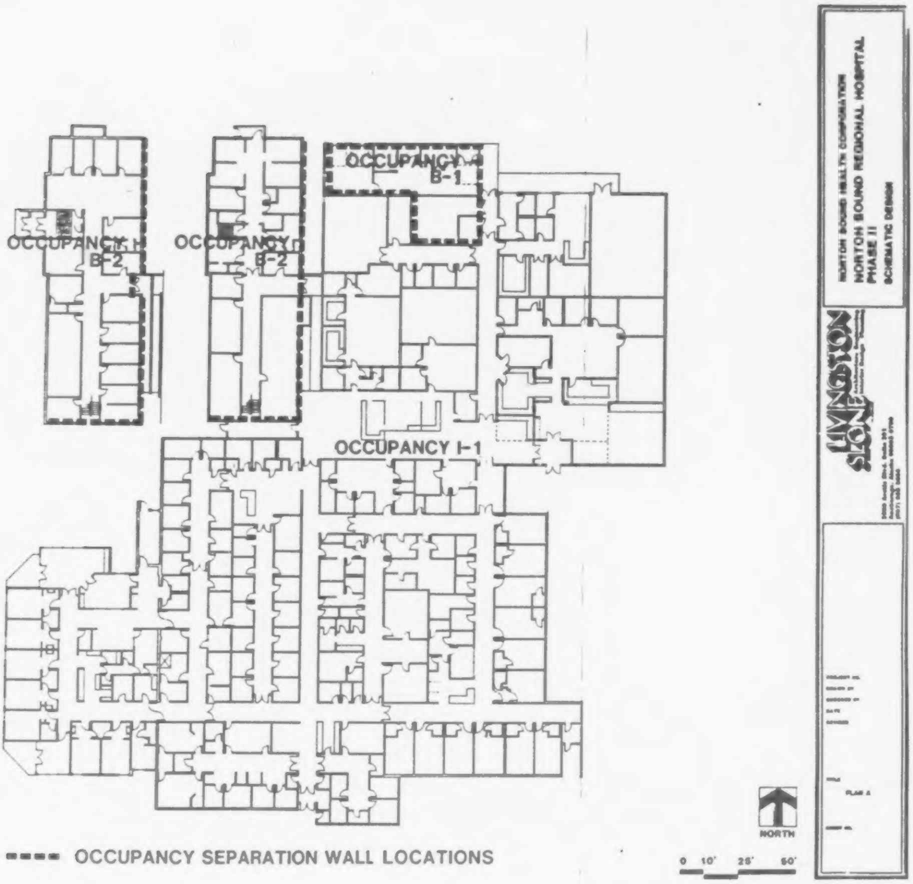
"The minimum clear width of a corridor shall be 44 inches except that corridors serving any area housing one or more nonambulatory persons shall be not less than 8 feet in width. Any change in elevation of the floor in a corridor serving nonambulatory persons shall be made by means of a ramp with a slope not exceeding 1 in 12."

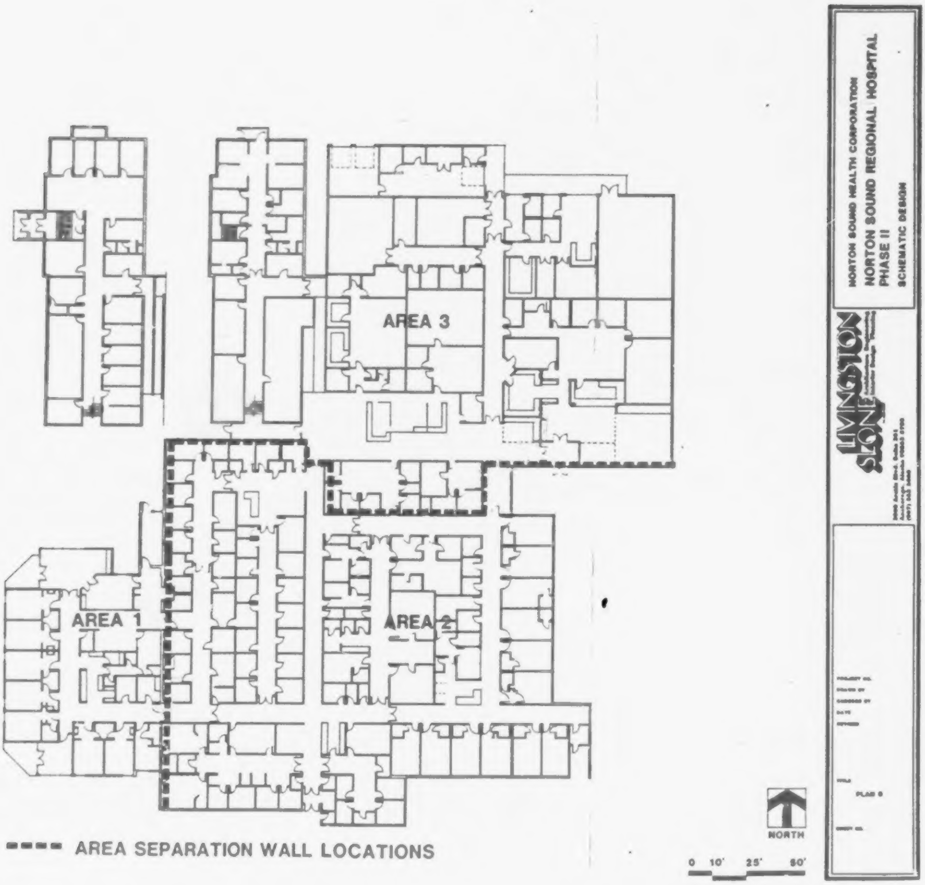
Applicable Codes/Standards:

1985 Uniform Building Code (UBC).
1985 Uniform Plumbing Code (UPC).
1985 Uniform Mechanical Code (UMC).
1985 Uniform Fire Code (UFC).
1987 National Electric Code (NEC).
1981 National Fire Code/NFPA.
1985 State Amendments.
ANSI A117.1-1980.

DHEW: Minimum requirements of construction and equipment for hospital and medical facilities, publication no. (HRA) 79-14500, 1987 edition.

HFPM: Indian Health Service: Health Facility Planning Manual prepared by Health and Human Services Public Health Service.


OCCUPANCY B-2
OCCUPANCY B-2
OCCUPANCY B-1
OCCUPANCY I-1
OCCUPANCY SEPARATION WALL LOCATIONS
NORTH
0 10' 25' 50'
NORTON SOUND HEALTH CORPORATION
NORTON SOUND REGIONAL HOSPITAL
PHASE II
SCHEMATIC DESIGN
LIVINGSTON SLONE
PLAN A


AREA 3
AREA 1
AREA 2
▬ ▬ ▬ ▬ AREA SEPARATION WALL LOCATIONS
NORTH
0 10' 25' 50'
NORTON SOUND HEALTH CORPORATION
NORTON SOUND REGIONAL HOSPITAL
PHASE II
SCHEMATIC DESIGN
LIVINGSTON SLONE
PROJECT NO.
DRAWN BY
CHECKED BY
DATE
REVISED
TITLE
SHEET NO.

XIV. STATEMENTS OF PROBABLE CONSTRUCTION COST

PHASE IIA: (Basis 1990-91 Construction Season: Year One)

ITEM	QTY.	UNIT	COST/UNIT	TOTAL	
1) DEMOLITION					
East portion of East Wing, 1948 Bldg.	3,202	SF	$ 24.00/SF	$ 76,848	
Misc. Int.	7,392	SF	$ 12.00/SF	88,704	
SUBTOTAL DEMOLITION					$ 165,552
2) CONSTRUCTION					
Employee Facilities	264	SF	$ 258.00/SF	$ 68,112	
Housekeeping & Linen	1,195	SF	$ 255.00/SF	304,725	
Dietetics	2,870	SF	$ 337.00/SF	967,190	
Consultation/Training	560	SF	$ 208.00/SF	116,480	
	4,889	SF			
Subtotal Construction x 1.2				$1,456,507	
Floor Gross Area Factor = 5867 SF				291,301	
Mechanical Room (Major)	3,532	SF	$ 190.00/SF	671,080	
	9,400	SF			
SUBTOTAL CONSTRUCTION					$ 2,418,888
3) PROJECT COSTS					
Relccate existing Kitchen, Housekeeping, Linen and Physical Plant Office into new construction. (Allowance)				$ 25,000	
Movable Equipment @ 15% of Constuction Cost				$ 387,666	
Furnishings @ 10% of Construction Cost				258,444	
Plan Check, Inspection, and Health Agency Fees				14,000	
SUBTOTAL PROJECT COSTS					$ 685,110
Construction Contingency				$ 516,888	
TOTAL PHASE IIA					$ 3,786,438

PHASE IIB (Year Two Construction)

ITEM	QTY.	UNIT	COST/UNIT	TOTAL	
1) DEMOLITION					
Remainder of East Wing of 1948 Bldg.	7,322	SF	$ 24.00/SF	$ 175,728	
Exist. Mtl. Bldgs.	2,720	SF	$ 24.00/SF	65,280	
	10,042	SF			
Subtotal Demolition + 5% Escalation for One Additional Year				$ 12,050	
SUBTOTAL DEMOLITION					$ 253,058
2) CONSTRUCTION					
Public Facilities	2,200	SF	$ 173.00/SF	$ 380,600	
Health Records	1,760	SF	$ 208.00/SF	366,080	
Laboratory & Pathology	1,480	SF	$ 258.00/SF	381,840	
Maintenance	1,420	SF	$ 162.00/SF	230,040	
Central Stores	1,870	SF	$ 162.00/SF	302,940	
Building Services	160	SF	$ 162.00/SF	25,920	
	8,890	SF			
Subtotal Construction x 1.20				$ 1,687,420	
Floor Gross Area Factor = 10,668 SF				337,484	
Subtotal Construction				$ 2,024,904	
+ 5% Escalation for One Additional Year				101,245	
SUBTOTAL CONSTRUCTION					$ 2,126,149
3) RENOVATION					
General Stores	990	SF	$ 14.00/SF	$ 13,860	
Business Office	720	SF	$ 14.00/SF	10,080	
	1,710	SF			
Subtotal Remodel				$ 23,940	
+ 5% Escalation for One Additional Year				1,197	
SUBTOTAL RENOVATION					$ 25,137

PHASE IIB (Year Two Construction)

ITEM	TOTAL	
4) PROJECT COSTS		
Relocate existing Departments into Phase IIB. (Allowance)	$ 75,000	
Movable Equipment @ 15% of Construction Cost	$ 360,652	
Furnishings @ 10% of Construction Cost	240,434	
Plan Check, Inspection, and Health Agency Fees	12,000	
SUBTOTAL PROJECT COSTS		$ 688,086
Construction Contingency	$ 480,869	
TOTAL PHASE IIB		$ 3,573,299

PHASE IIC (Year Three Construction)

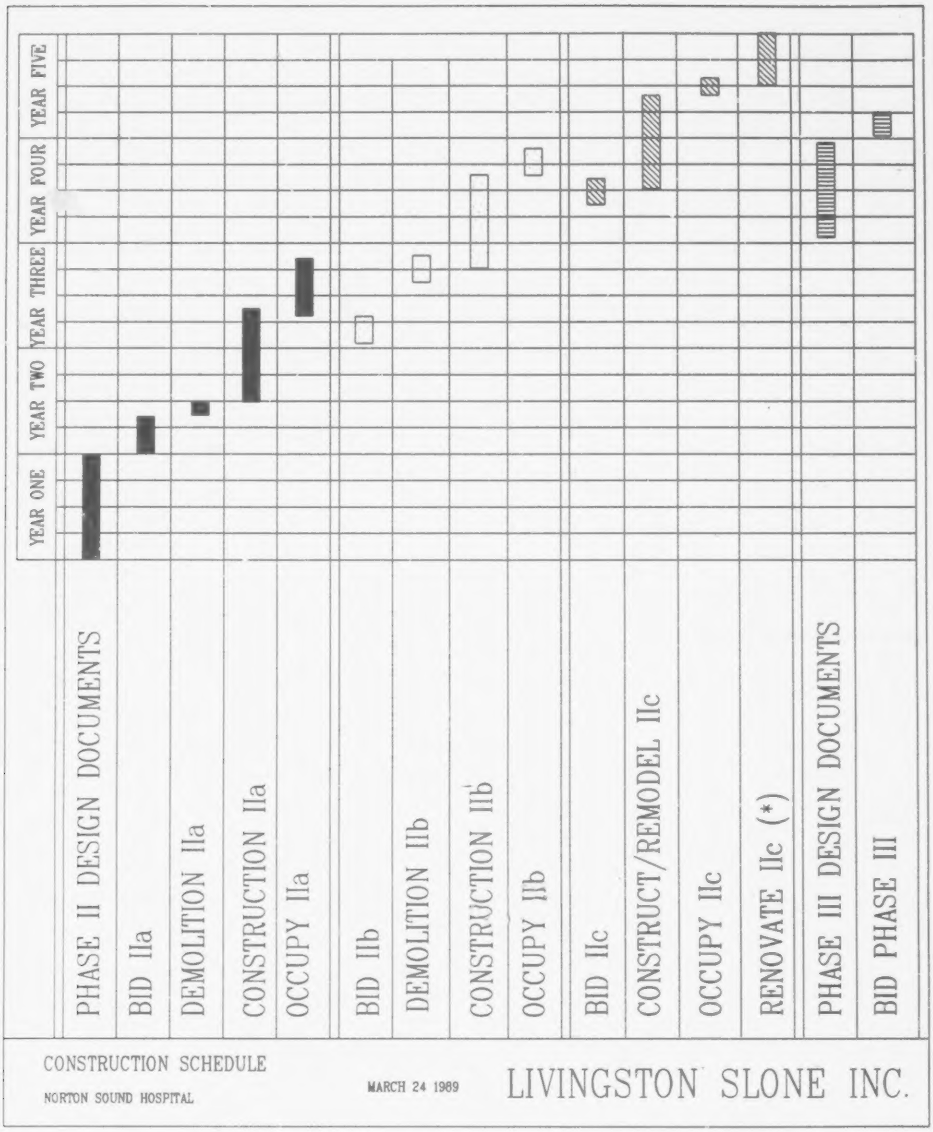
ITEM	QTY.	UNIT	COST/UNIT	TOTAL	
1) REMODEL AND RENOVATION					
1978 Building Remodel					
Patient Rooms (4)	1,400	SF	$142.00/SF	$ 198,800	
Patient Rooms (6)	2,100	SF	$ 40.00/SF	84,000	
Nursery	537	SF	$139.00/SF	74,643	
Acute Care Nursing	1,975	SF	$139.00/SF	274,525	
Delivery/Surgery	1,760	SF	$ 40.00/SF	70,400	
Support	1,627	SF	$139.00/SF	226,153	
Radiology	1,140	SF	$139.00/SF	158,460	
Emergency	943	SF	$232.00/SF	218,776	
Outpatient	2,882	SF	$128.00/SF	368,896	
Outpatient	1,114	SF	$ 28.00/SF	31,192	
Physical Therapy	1,482	SF	$132.00/SF	195,624	
Respiratory Therapy	689	SF	$132.00/SF	90,948	
Central Sterile	840	SF	$234.00/SF	196,560	
	18,489	SF			
SUBTOTAL 1978 BUILDING REMODEL					$ 2,188,977
1948 Building Renovation:					
Pharmacy	972	SF	$173.00/SF	$ 168,156	
Computers	420	SF	$ 71.00/SF	29,820	
Corridors	264	SF	$ 61.00/SF	16,104	
Stairs	1	Flight	$8,700/FLT	8,700	
	1,657	SF			
Subtotal 1948 Building Renovation				$ 222,780	
Subtotal Building Remodel & Renovation				$ 2,411,757	
5%/Year Inflation from Year One				247,205	
SUBTOTAL BUILDING REMODEL & RENOVATION					$ 2,658,962

PHASE IIC (Year Three Construction)

ITEM	QTY.	UNIT	COST/UNIT	TOTAL	
2) CONSTRUCTION					
Patient Rooms (2)	840	SF	$232.00/SF	$ 194,880	
Radiology Expansion	1,042	SF	$290.00/SF	302,180	
Emergency Expansion	1,080	SF	$268.00/SF	289,440	
	2,962	SF			
Subtotal Construction x 1.20				$ 786,500	
Floor Gross Area Factor = 2962 SF				157,300	
Subtotal Construction				$ 943,800	
+ 5%/Year Inflation from year one				96,740	
SUBTOTAL CONSTRUCTION					$ 1,040,540
3) SITE WORK					
Parking & Landscaping at SE Corner	10,000	SF	$ 10.00/SF	$ 100,000	
Upgrade Existing Parking at NW Corner	10,000	SF	$ 3.00/SF	30,000	
Subtotal Sitework				$ 130,000	
+ 5%/Year Inflation from Year One				13,325	
SUBTOTAL SITE WORK					$ 143,325
4) PROJECT COSTS					
Relocate existing Departments into Phase IIC (Allowance)				$ 75,000	
Moveable Equipment @ 15% of Construction Costs				576,424	
Furnishings @ 10% of Construction Costs				384,283	
Plan Check, Inspection and Health Agency Fees				15,000	
SUBTOTAL PROJECT COSTS					$ 1,050,707
Construction Contingency				$ 768,565	
TOTAL PHASE IIC					$ 5,662,099

TOTAL CONSTRUCTION COST PHASE II

PHASE IIA	$ 3,786,438	
PHASE IIB	3,573,299	
PHASE IIC	5,662,099	
TOTAL PHASE II		$ 13,021,836



CONSTRUCTION SCHEDULE
NORTON SOUND HOSPITAL
MARCH 24 1989
LIVINGSTON SLONE INC.

SUMMARY OF ATTACHMENTS
REGARDING
IHS FACILITY REPLACEMENT
AT
LAPWAI, IDAHO
1990

I. DOCUMENTS RELATED TO THE CONDITION OF THE LAPWAI CLINIC

A. U.S. P.H.S. Health Service Real Property Inventory citing clinic as INADEQUATE
B. Deficiency Code Summary 3-8-90 for Lapwai Clinic
C. Annual Comprehensive Survey Report on March 26, 1987 which evaluates the clinic under "Business Occupancy rather than ... Ambulatory Health Care"
D. DHHS/PHS Comprehensive Environmental Health Survey Report April 1989

II. ATTEMPTS TO REPLACE THE FACILITY THROUGH THE PRIORITY LIST

A. Phase I Scores, Health Facility Construction Priority System for Portland Area nominating the Lapwai Clinic to be Replaced December 5, 1988
B. Memo from Bill Pearson, Associate Director for Office of Environmental Health and Engineering for IHS stating that repair and renovation funds will be provided for Lapwai Clinic "...this temporary space will resolve a critical problem until the facility can be replaced in the **normal permanent construction cycle**..." 10-28-88
C. Letter from Fred Baker, IHS Director Northern Idaho Service Unit stating that repairs and renovation cannot be held up in favor of facility replacement and that "...staff...agreed very strongly that the **chances of getting on the construction priority list were 'so slim'** that we should not jeopardize the ... plans . 1-23-90

III. HISTORY OF FACILITIES BUILT UNDER THE CURRENT PRIORITY SYSTEM

A. List provided by IHS of facilities constructed since 1980
B. Map showing where the Outpatient and Inpatient facilities have been built by state, including those facilities "in progress" over the last 10 years.

IV. CORRESPONDENCE WITH THE IHS ON FACILITY REPLACEMENT NEEDS

A. Letter from Chairman of the Nez Perce Tribe to Portland Area Director 1-23-90
B. Letter from the Portland Area Director to the Nez Perce Tribe stating "...A new facility built to current IHS standards would be much larger than the existing ...Center...whose replacement is being requested...My staff has commented on certain aspects of this system in hopes of making it more even handed toward the **smaller tribes in the Portland Area**..." 2-9-90
C. Letter from Dr. Rhoades, Director IHS regarding a leasing priority list methodology for clinics smaller than 10,000 square feet. "IHS ...has no mechanism for supporting such projects (if greater than 10,000 GSF); however, **if the Congress so directs, the IHS would develop an alternate priority system for rating projects of this nature.**" 3-9-90
D. Memo from Wesley M. Bell, IHS Portland Area Division of Facilities Engineering describing the square footage needs and cost estimates for a new facility at Lapwai Clinic assuming certain patient utilization rate. Results show building between 22,000 GSF and 28,000 GSF at a cost of $3 million to $3.8 million.

cato20
2/05/88

U. S. PUBLIC HEALTH SERVICE REAL PROPERTY INVENTORY

INSTALL: 20944
LAPWAI.ID

HRSA- INDIAN HEALTH SERVICE
IHS IND HLTH CTR
PORTLAND OFFICE

Street: City: LAPWAI County: NEZ PERCE State: ID Zipcode: 83540 HHSRegion: 10

City Code: 0930 County Code: 069 State Code: 16 Real Property Unit-- Code: PO Name: RPU IHS AREA PORTLAND OR

Congressional District: 01 Location: URBAN Authorized Positions: 0 for Office; 11 for Installation

-------- LAND ----------

LAND NUMBER	SUB LAND NUMBER	USE DESCRIPTION	FACILITY DESCRIPTION	CATEGORY CODE	LAND ACQUISITION DESCRIPTION	ACQUISITION DATE	DISPOSAL DESCRIPTION	AMOUNT	AMOUNT OTHER	BOOK VALUE

---------- INSTALLATION SUMMARY ----------

---------- BUILDINGS ----------

USE DESCRIPTION	NUMBER OF BUILDINGS	GROSS SQ FEET	COST	ACQ FROM DATE	ACQ TO DATE
OFFICE	2	2,273	$12,000	1918	1970
OTHER INSTITUTIONAL	2	5,671	$179,000	1962	1970
SERVICE	1	144	$3,000	1972	1972
TOTAL	5	8,088	$194,000		

---------- STRUCTURES ----------

USE DESCRIPTION	NUMBER OF STRUCTURES	GROSS SQ FEET	COST	ACQ FROM DATE	ACQ TO DATE
SERVICE	3	0	$20,000	1970	1980
ROADS & BRIDGES	1	0	$1,000	1970	1970
TOTAL	4	0	$21,000		

TOTAL INSTALLATION BOOKVALUE = $215,000

-------- INSTALLATION QUARTERS SUMMARY --------

EMPLOYEE MULTI-UNIT BLDGS	EMPLOYEE MULTI-UNIT SQFT	EMPLOYEE APARTMENT UNITS	EMPLOYEE APARTMENT SQFT	EMPLOYEE RESIDENCES BLDGS	EMPLOYEE RESIDENCES SQFT	EMPLOYEE TRAILERS NUMBER	EMPLOYEE TRAILERS SQFT	EMPLOYEE DORMITORY & ROOM NUMBER	EMPLOYEE DORMITORY & ROOM SQFT	EMPLOYEE DORMITORY NUMBER	EMPLOYEE DORMITORY SQFT	EMPLOYEE NONHOUSEKEEPING UNITS	EMPLOYEE NONHOUSEKEEPING SQFT	PATIENT DORMITORY BLDGS	PATIENT DORMITORY SQFT	TRANSIENT NONHOUSEKEEPING UNITS	TRANSIENT NONHOUSEKEEPING SQFT	TENANT HOUSING BLDGS	TENANT HOUSING SQFT	STUDENT DORMITORY BLDGS	STUDENT DORMITORY SQFT	STUDENT DORMITORY UNITS	STUDENT DORMITORY SQFT
0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0

TOTAL NUMBER OF LIVING UNITS = 0

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cato20
2/05/88                        U. S. PUBLIC HEALTH SERVICE REAL PROPERTY INVENTORY                                           PAGE 2

                                               HRSA- INDIAN HEALTH SERVICE                                            INSTALL: 20944
                                                  IHS IND HLTH CTR                                                       LAPWAI,ID
                                                   PORTLAND OFFICE

                                         -------- BUILDINGS AND STRUCTURES --------

                                                                                         NUMBER
                        BUILDING SUB-BUILD                      FACILITY     CATEGORY ACQUISITION  NUMBER                OF UNITS                          BOOK    OCCUP
FAC TYPE  BUILDING NAME NUMBER   NUMBER   USE DESCRIPTION       DESCRIPTION  CODE     DATE         OF UNITS DESCRIPTION  OTHER    DESCRIPTION              VALUE    %

BLD                     00025             OFFICE                ADMIN OFF CEN 331307  1910         1,033 GROSS SQ FEET      0                              $3,000   100
                                            CONSTRUCTION: PERMANENT            CONDITION: STRUCTURALLY SOUND        STANDARD: ADEQUATE

BLD                     00102             OFFICE                ADMIN OFF CEN 331307  1970           440 GROSS SQ FEET      0                              $9,000   100
                                            CONSTRUCTION: RELOCATABLE TRAILER  CONDITION: STRUCTURALLY SOUND        STANDARD: ADEQUATE

BLD                     00001             OTHER INSTITUTIONAL   HEALTH CENTER 333382  1970         5,511 GROSS SQ FEET      0                            $142,000   100
                                            CONSTRUCTION: PERMANENT            CONDITION: STRUCTURALLY SOUND        STANDARD: INADEQUATE

  SUB BLD               00001    B15      OTHER INSTITUTIONAL   HEAT PLNT CLPW 322053 1970             0                   15 MANHOLE           CONDITION:
  SUB BLD               00001    B16      OTHER INSTITUTIONAL   FIRE SPRNK WET 328199 1981           233 SQUARE FEET        0                   CONDITION: STRUCTURALLY SOUND
BLD                     00104             OTHER INSTITUTIONAL   DENTAL TRAILR 333374  1962           160 GROSS SQ FEET      0                             $37,000   100
                                            CONSTRUCTION: RELOCATABLE TRAILER  CONDITION: STRUCTURALLY SOUND        STANDARD: ADEQUATE

BLD                     00002             SERVICE               FAC MAINT SHOP 334398 1972           144 GROSS SQ FEET    150                              $3,000   100
                                            CONSTRUCTION: PERMANENT            CONDITION: STRUCTURALLY SOUND        STANDARD: ADEQUATE

STR                     00003             SERVICE               INCINRATR GAS 350765  1980            85 POUNDS PER/HOUR  150 1000 BTU/HOUR               $15,000   100
                                            CONSTRUCTION: PERMANENT            CONDITION: STRUCTURALLY SOUND        STANDARD: ADEQUATE

STR                     00012             SERVICE               FLAG POLE     340601  1970             0                    1 EACH                         $1,000   100
                                            CONSTRUCTION: PERMANENT            CONDITION: STRUCTURALLY SOUND        STANDARD: ADEQUATE

STR                     00112             SERVICE               VE PARK AREA B 373839 1970           750 SQUARE YARDS      20 VEHICLE(S)                   $4,000   100
                                            CONSTRUCTION: PERMANENT            CONDITION: STRUCTURALLY SOUND        STANDARD: ADEQUATE

STR                     00022             ROADS AND BRIDGES     SIDEWALK      373830  1970            84 SQUARE YARDS       0                              $1,000   100
                                            CONSTRUCTION: PERMANENT            CONDITION: STRUCTURALLY SOUND        STANDARD: ADEQUATE
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*** DEFICIENCY CODE SUMMARY ***

rec'd 3-8-90 (position)

INSTALLATION: NEAH BAY

CODE	DEFICIENCY	TOTAL $	$ REDUCED	% REDUCTION	REMARKS
01	Patient Care	$0	$0	0.00	FY 89 PROJECT
02	Fire/Life Safety	$21,300	$1,000	0.00	
03	Safety	$0	$0	0.00	
04	Environmental Quality	$0	$0	0.00	
05	Program	$3,700	$0	0.00	
06	Other	$0	$0	0.00	
07	Handicapped	$0	$0	0.00	
08	Energy Management	$0	$0	0.00	
11	BEMAR Structural	$21,150	$2,000	9.46	DENTAL TRAILERS
12	BEMAR Mechanical	$8,000	$0	0.00	"
13	BEMAR Electrical	$4,550	$0	0.00	"
14	BEMAR Utilities	$3,000	$0	0.00	"
15	BEMAR Grounds	$7,500	$0	0.00	"
16	BEMAR Quarters	$19,453	$0	0.00	"
	SUMMARY	$88,653	$3,000	3.38	

INSTALLATION: NORTHERN IDAHO

CODE	DEFICIENCY	TOTAL $	$ REDUCED	% REDUCTION	REMARKS
01	Patient Care	$0	$0	0.00	
02	Fire/Life Safety	$98,800	$85,600	86.64	
03	Safety	$50	$50	0.00	
04	Environmental Quality	$8,500	$4,000	0.00	
05	Program	$0	$0	0.00	
06	Other	$0	$0	0.00	
07	Handicapped	$0	$0	0.00	
08	Energy Management	$5,000	$5,000	0.00	
11	BEMAR Structural	$1,485	$0	0.00	
12	BEMAR Mechanical	$150	$0	0.00	
13	BEMAR Electrical	$185	$0	0.00	
14	BEMAR Utilities	$800	$0	0.00	
15	BEMAR Grounds	$0	$0	0.00	
16	BEMAR Quarters	$0	$0	0.00	
	SUMMARY	$114,970	$94,650	82.33	

INDIAN HEALTH SERVICE
DIVISION OF FA' ' MANAGEMENT
FACILITIES ENGINEEI IENCIES SYSTEM

6/16/89 9:09 am

SERVICE UNIT: NORTHERN IDAHO

INS AREA: PD

Inst#	Installation Description	Bldg#	USE	Bldg Description	FEDS#	DL	T W	Description of Deficiency	Estimated COST	S T	D Y	Last Update	Project	#	- - - - - PROPOSED CORRECTIVE ACTION - - - - - - - - - -	REMARKS
20944	LAPWAI	00001	HCTR	HEALTH CENTER	2	2	A	INTERIOR BASEMENT EXIT STAIRS NOT MEETING LSC FOR EXIT	$ 0	D	O	11/88	PD8NI422C7	7	REROUTE STAIRS AND PROVIDE STAIR ENCLOSURE.	89RI
20944	LAPWAI	00001	HCTR	HEALTH CENTER	3	2	A	CORRIDOR DOORS NOT MEETING LSC REQUIREMENT OF 20 MIN	$ 0	D	O	11/88	PD8NI422C7	7	REPLACE EXISTING DOORS AND DOOR FRAMES WITH DOORS MEETING LSC REQUIREMENTS FOR CORRIDOR ENCLOSURE.	89RI
20944	LAPWAI	00001	HCTR	HEALTH CENTER	5	2	A	WIRED GLASS WINDOW IN DOOR REQUIRED BY LSC AT STAIRS	$ 0	D	O	11/88	PD8NI422C7	7	REMOVE EXISTING WINDOW AND INSTALL FIXED WIRED GLASS WINDOW WITH METAL FRAME TO PROTECT OCCUPANTS EXITING THE BASEMENT THROUGH THE STAIRWAY.	89RI
20944	LAPWAI	00001	HCTR	HEALTH CENTER	6	2	M	HOLES IN MECH RM CEILING OPEN TO SUBFLOOR ABOVE.	$ 0	D	O	11/88	PD8NI422C7	7	REMOVE DAMAGED MATERIALS, REFRAME AS NEEDED AND ADD SUBFLOOR, FLOORING AND TYPE "X" GYP BD. FILL ALL VOIDS WITH FIRE SAFE INSULATION.	89RI
20944	LAPWAI	00001	HCTR	HEALTH CENTER	8	2	A	EXTERIOR SLAB DOES NOT MEET FLOOR HEIGHT PER LSC	$ 0	D	O	11/88	PD8NI422C7	7	REMOVE SLAB AND PLANTER AT ENTRANCE AND REPLACE WITH CONCRETE SLAB TO MEET FLOOR ELEVATION OF CLINIC, PLANT SCUBS ALONG SIDEWALK TO MARK ENTRY.	89RI
20944	LAPWAI	00001	HCTR	HEALTH CENTER	29	2	M	EXIT SIGN NOT OPERATING.	$ 0	D	O	11/88	PD8NI422C7	7	REPLACE BATTERY AND CHARGER ON EXIT SIGN LOCATED AT EAST END OF CORRIDOR.	89RI
20944	LAPWAI	00001	HCTR	HEALTH CENTER	54	2	M	BUILDING REQUIRES DEMAR PROJECT	$ 90,800	F	O	12/88	PD9NI422C7	7	CORRECT [illegible] LSC DEFICIENCIES AND DEMAR VIA FY88 R & I P[illegible]	89RI
								2 TOTAL	$ 90,800							
20944	LAPWAI	00001	HCTR	HEALTH CENTER	4	3	A	EXISTING SPRINKLER TO BE EXTENDED ABOVE CEILING SPACE	$ 0	D	O	11/88	PD8NI422C7	7	NO REQUIREMENT BY LSC FOR SPRINKLERS, BUT AS SPRINKLERS ARE IN PLACE IN BASEMENT AREA THESE SHOULD BE EXTENDED TO PROVIDE PROTECTION IN INTERSTACIAL SPACE.	89RI
20944	LAPWAI	00001	HCTR	HEALTH CENTER	7	3	A	ITEMS STORE IN CORRIDORS.	$ 0	D	O	11/88	PD8NI422C7	7	REMOVE ALL ITEMS FROM CORRIDORS AND INSTALL SHELVING IN ALL STORAGE AREAS AND PROVIDE SMALL DESIGN AND CONSTRUCTION PROJECT TO RE-EVALUATE USER STORAGE.	89RI
20944	LAPWAI	00001	HCTR	HEALTH CENTER	30	3	M	FIXTURE LENSES MISSING.	$ 0	D	O	11/88	PD8NI422C7	7	REPLACE FIXTURES (2) IN THE MAIN ENTRY.	89RI
20944	LAPWAI	00001	HCTR	HEALTH CENTER	31	3	M	WIRING LOOSE AND EXPOSED ON FIN TUBE CONTROL.	$ 0	D	O	11/88	PD8NI422C7	7	CAP WIRING AND STORE WITHIN FIN TUBE CABINET.	89RI
20944	LAPWAI	00104	DSTA	DENTAL TRAILER	35	3	A	OPENINGS ON PORCH RAILING > 6 INCHES	$ 50	N	U	11/88	PD C5	5	ADD BOARDS TO MAKE < 6 INCH OPENINGS ON PORCH RAIL, TO CONFORM TO UBC, SECTION 1711.	
								3 TOTAL	$ 50							
20944	LAPWAI	00001	HCTR	HEALTH CENTER	15	4	M	INTERIOR NEEDS PAINTING	$ 0	D	O	11/88	PD8NI422C7	7	REPAINT INTERIOR	89RI
20944	LAPWAI	00001	HCTR	HEALTH CENTER	17	4	M	EXISTING CARPETING IS WORN.	$ 0	D	O	11/88	PD8NI422C7	7	REPLACE CARPETING IN CORRIDORS, WAITING AREAS, EXAM ROOMS AND OFFICES.	89RI
20944	LAPWAI	00025	ADMN	ADMINISTRATION	52	4	M	ASBESTOS ABATEMENT	$ 8,500	M	A	11/88	PD8NI00C26	6	REMOVE ASBESTOS DEBRIS IN BASEMENT AND DUCT TAPE ON FURNACE.	52
								4 TOTAL	$ 8,500							

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                                                         DIVISION OF FACILITIES MANAGEMENT
                                                  FACILITIES ENGINEER[illegible]FICIENCIES SYSTEM
                                                                                                                                          2
6/16/89  9:09 a

SERVICE UNIT: NORTHERN IDAHO                                                                                                   IHS AREA: PD

                                                        T                                   Estimated  S D  Last
Inst# Installation Description Bldg# USE  Bldg Description  FEDS# DL N  Description of Deficiency    COST    T Y  Update Project    $  - - - - - PROPOSED CORRECTIVE ACTION - - - - - - - - - -  REMARKS
------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

20944 LAPWAI                  00001 HCTR HEALTH CENTER     9  7 A  NO HANDICAP ACCESSIBLE     $        0 D D  11/88 PD0N1422C7  7  ENLARGE PATIENT TOILET SPECIMEN ROOM, DEMO WALL, RELOCATE  89RI
                                                                   RESTROOM IN CLINIC                                              PIPING AND FIXTURES, REBUILD WALL, PATCH TO MATCH,
                                                                                                                                   PROVIDE NEW DOOR.
20944 LAPWAI                  00001 HCTR HEALTH CENTER    12  7 A  DOOR IN NEED OF REPAIR AND $        0 D D  11/88 PD0N1422C7  7  REMOVE EXISTING DOOR AND FRAME, INSTALL NEW.  INSTALL NEW  89RI
                                                                   NOT MEETING HANDICAP ACCESS                                     THRESHOLD AND SLAB TO MEET MIN HEIGHT REQUIREMENTS FOR
                                                                                                                                   HANDICAP ACCESS.

                                                                            7 TOTAL  $        0


20944 LAPWAI                  00001 HCTR HEALTH CENTER    56  8 R  IMPROVE ENERGY EFFICENCY   $    5,000 D D        PD0N1002C6  6  INSTALL EXTERIOR INSULATION WITH NEW SIDING AND REPLACE  90RD
                                                                                                                                   WINDOWS WITH NEW ENERGY EFFICENT DESIGN.  DESIGN ONLY
                                                                                                                                   FY90.

                                                                            8 TOTAL  $    5,000


20944 LAPWAI                  00001 HCTR HEALTH CENTER    14 11 R  REPAIR HOLES IN            $        0 D D  11/88 PD0N1422C7  7  REPLACE FLOORING AND REPAIR CEILINGS AS NEEDED.          89RI
                                                                   WALLS/CEILINGS, FLOOR REPAIRS.
20944 LAPWAI                  00001 HCTR HEALTH CENTER    32 11 R  ROOF NEEDS WORK, GUTTERS NEED $     0 D D  11/88 PD0N1422C7  7  REROOF, CAP ABANDONED VENT AND REPAIR GUTTERS.           89RI
                                                                   CLEANING
20944 LAPWAI                  00102 ADMN ADMINISTRATION   33 11 R  REPAIRS NEEDED TO ROOF,    $        0 D D  11/88 PD0N1422I7  7  RENOVATE TRAILER, DEMO EXISTING BREEZEWAY AND REPLACE.   89RI
                                                                   INTERIOR WALLS AND STRUCTURE
20944 LAPWAI                  00104 DSTA DENTAL TRAILER   34 11 R  FRONT PORCH NEEDS PAINT    $       50 C S  11/88 PD         C0  0  PAINT PORCH
20944 LAPWAI                  00104 DSTA DENTAL TRAILER   36 11 R  METAL TRIM OVER DOOR IS LOOSE $    10 N S  11/88 PD         C6  6  SECURE METAL DOOR TRIM
20944 LAPWAI                  00104 DSTA DENTAL TRAILER   37 11 R  DOOR HINGES NEED REPLACEMENT $    150 N U  11/88 PD         C6  6  REPLACE DOOR HINGES
20944 LAPWAI                  00104 DSTA DENTAL TRAILER   39 11 R  SUPPORT BLOCKING MISSING ON $      25 N U  11/88 PD         C6  6  INSTALL SUPPORT BLOCKING
                                                                   FRONT CORNER.
20944 LAPWAI                  00104 DSTA DENTAL TRAILER   40 11 R  SKIRTING NEEDED AROUND TRAILER $  500 C S  11/88 PD         C0  0  INSTALL SKIRTING
20944 LAPWAI                  00104 DSTA DENTAL TRAILER   45 11 R  BROKEN WALL PANELING       $      200 N U  11/88 PD         C6  6  PATCH OR REPLACE PANELING AS REQUIRED
20944 LAPWAI                  00104 DSTA DENTAL TRAILER   49 11 R  LOOSE METAL STRIPS ON      $      200 N U  11/88 PD         C6  6  REATTACH OR REPLACE METAL STRIPPING.
                                                                   PLUMBING ACCESS DOORS
20944 LAPWAI                  00104 DSTA DENTAL TRAILER   50 11 A  NO STEPS AT REAR OF TRAILER. $    350 C S  11/88 PD         C0  0  CONSTRUCT OR PURCHASE STEPS FOR BACK OF TRAILER.

                                                                           11 TOTAL  $    1,405


20944 LAPWAI                  00001 HCTR HEALTH CENTER    16 12 A  JAN CLOSET NEEDS 1HR WALL, $        0 D D  11/88 PD0N1422C7  7  REMOVE LOUVER IN DOOR AND RUN MECHANICAL EXHAUST TO       89RI
                                                                   ALSO EXHAUST                                                    JANITOR CLOSET AND SEPARATE SYSTEM IN WOMENS TOILET.
20944 LAPWAI                  00001 HCTR HEALTH CENTER    19 12 A  NO OUTSIDE VENTILATION AIR $        0 D D  11/88 PD0N1422C7  7  UPGRADE EXISTING VENTILATION SYSTEM TO BRING IN OUTSIDE   89RI
                                                                   PROVIDED TO BASEMENT AREAS                                      AIR.
20944 LAPWAI                  00001 HCTR HEALTH CENTER    20 12 A  NO EXISTING DENTAL LAB EXHAUST $    0 D D  11/88 PD0N1422C7  7  INSTALL WALL MOUNTED FAN EXHAUST TO REMOVE ACRYLATE FUMES 89RI
                                                                                                                                   AND GRINDING DUST.
20944 LAPWAI                  00001 HCTR HEALTH CENTER    21 12 A  NO VENTILATION EXHAUST FOR $        0 D D  11/88 PD0N1422C7  7  INSTALL EXHAUST FOR DENTAL AREA.                         89RI
                                                                   DENTAL
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INDIAN HEALTH SERVICE
DIVISION OF FA ES MANAGEMENT
FACILITIES ENGINE ICIENCIES SYSTEM

6/16/89 9:09 a

.age 3

SERVICE UNIT: NORTHERN IDAHO

IHF AREA: PD

Inst#	Installation Description	Bldg#	USE	Bldg Description	FEDS#	DL	T W	Description of Deficiency		Estimated COST	B T	B Y	Last Update	Project		$	PROPOSED CORRECTIVE ACTION	REMARKS
20944	LAPWAI	00001	MCTR	HEALTH CENTER	22	12	A	RETURN AIR MODIFICATION NEEDED.	$	0	D	0	11/88	PD0NI422C7		7	REMOVE TRANSFER GRILLS IN DOORS TO CORRIDOR TO MAINTAIN 20 MINUTE RATING FOR EGRESS AND INSTALL RETURN AIR DUCTWORK.	89RI
20944	LAPWAI	00104	DSTA	DENTAL TRAILER	42	12	A	EXHAUST IN LAB NOT WORKING AND GRINDER HAS NO EXHAUST	$	100	N	U	11/88	PD	C5	5	REPAIR EXHAUST IN LAB AND INSTALL EXHAUST TO GRINDER.	
20944	LAPWAI	00104	DSTA	DENTAL TRAILER	44	12	R	PLUMBING NOT TO CODE AND RELIEF VALVE TO SMALL	$	50	N	U	11/88	PD	C6	6	REMOVE 1/2" PVC PIPE AND INSTALL 3/4" COPPER LINE FOR DISCHARGE.	
								12 TOTAL	$	150								
20944	LAPWAI	00001	MCTR	HEALTH CENTER	25	13	R	SPRING TENSION IN OUTLETS IS MINIMAL	$	0	D	0	11/88	PD0NI422C7		7	REPLACE ALL ELECTRICAL OUTLETS IN BASEMENT.	89RI
20944	LAPWAI	00001	MCTR	HEALTH CENTER	26	13	A	ELECTRICAL HAZARD DUE TO WIRE HANGING DOWN FROM FIXTUR	$	0	D	0	11/88	PD0NI422C7		7	REPLACE FIXTURE WIRING TO THE JUNCTION BOX.	89RI
20944	LAPWAI	00001	MCTR	HEALTH CENTER	27	13	R	ACCESS TO POWER PANEL BLOCKED, RELABEL PANEL	$	0	D	0	11/88	PD0NI422C7		7	REMOVE STORAGE ITEMS FROM IN FRONT OF POWER PANEL IN NUTRITION ROOM AND UPDATE PANEL SCHEDULE.	89RI
20944	LAPWAI	00001	MCTR	HEALTH CENTER	28	13	A	GFI PROTECTORS NEEDED ABOVE SINK IN LAB	$	0	D	0	11/88	PD0NI422C7		7	INSTALL GFI PROTECTORS ABOVE SINK IN LAB	89RI
20944	LAPWAI	00104	DSTA	DENTAL TRAILER	41	13	A	LAB LIGHTING AT 22FC NEEDS TO BE 100FC	$	125	N	U	11/88	PD	C5	5	INSTALL NEW LIGHTING	
20944	LAPWAI	00104	DSTA	DENTAL TRAILER	46	13	R	CRACKED LIGHT COVER	$	10	N	U	11/88	PD	C6	6	REPLACE LIGHT COVER	
20944	LAPWAI	00104	DSTA	DENTAL TRAILER	48	13	R	LIGHT NOT WORKING OVER DENTAL CHAIR	$	50	N	U	11/88	PD	C6	6	REPAIR LIGHT	
								13 TOTAL	$	185								
20944	LAPWAI	00001	MCTR	HEALTH CENTER	23	14	A	FLOOR PROTECTION FROM FILM CHEM NEEDED	$	0	D	0	11/88	PD0NI422C7		7	INSTALL RECTANGULAR FLOOR MOUNTED SERVICE SINK TO ENCLOSE FILM PROCESSOR, INSTALL ACID RESISTANT PIPING FOR WASTE LINE.	89RI
20944	LAPWAI	00001	MCTR	HEALTH CENTER	24	14	R	LEAKING PLUMBING NEED REPAIR ALSO INSULATE PIPING.	$	0	D	0	11/88	PD0NI422C7		7	REPAIR LEAKS AND REPLACE PLUMBING AS NEEDED, INSTALL INSULATION ON PIPING.	89RI
20944	LAPWAI	00104	DSTA	DENTAL TRAILER	43	14	R	EXISTING WATER LINE FREEZES IN WINTER	$	500	N	U	11/88	PD	C5	5	INSULATE LINE AND APPLY HEAT TAPE	
20944	LAPWAI	00104	DSTA	DENTAL TRAILER	51	14	R	LEAKING PLUMBING	$	300	N	U	11/88	PD	C6	6	REMOVE LEAKING TANK AND INSTALL BYPASS PLUMBING.	
								14 TOTAL	$	800								
20944	LAPWAI	00001	MCTR	HEALTH CENTER	10	15	R	SURFACE WATER CARRIERS RUN INTO PARKING LOT IN BACK	$	0	D	0	11/88	PD0NI422C7		7	REMOVE EXISTING CURB AND PAVEMENT AT WEST ENTRANCE AND INSTALL NEW TO PREVENT FLOW OF WATER INTO PARKING AREA, INSTALL SIDEWALK AND SLOPE IT TO MATCH EXISTING PAVED AREA.	89RI
								15 TOTAL	$	0								

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                                                                                  [illegible]
                                                                       DIVISION OF FACILITIES MANAGEMENT
                                                                     FACILITIES ENGINEER'    'ICIENCIES SYSTEM
6/16/89  9:09 a

SERVICE UNIT: NORTHERN IDAHO                                                                                                                                   IHS AREA: PO

                                                           T                           Estimated  S D  Last
Inst# Installation Description Bldg# UBE  Bldg Description  FEDS# DL W  Description of Deficiency   COST     T T Update Project    0  - - - - - PROPOSED CORRECTIVE ACTION - - - - - - - - - -  REMARKS
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20944 LAPWAI                 00001 NCTR HEALTH CENTER     11 20 R  EXTERIOR NEEDS PAINTING     $   14,000 C S 11/88 PB       C6  6 PAINT EXTERIOR, REPAIR ALL CRACKS.                    COMPLETE ON CLINIC ONLY
20944 LAPWAI                 00001 NCTR HEALTH CENTER     13 20 A  CLINIC HAS HAD SEVERAL BREAK $   1,000 N U 11/88 PB       C5  5 INSTALL LOCAL AND REMOTE BURGLAR ALARM.
                                                                   INS.
20944 LAPWAI                 00001 NCTR HEALTH CENTER     53 20 R  DAILY OPERATIONS AND        $    6,300 D S 12/88 PD9HI001CA  6 LOCAL M & R ALLOWANCE FY 89.                          89RR
                                                                   MAINTENANCE
20944 LAPWAI                 00001 NCTR HEALTH CENTER     55 20 R  DAILY OPERATIONS AND        $    6,300 D S       PD90I001CA  6 LOCAL M & R ALLOWANCE FY90.                           90RR
                                                                   MAINTENANCE.
20944 LAPWAI                 00104 DSTA DENTAL TRAILER    38 20 R  BATTERY POST NEEDS CLEANING $       20 N U 11/88 PB       C6  6 CLEAN BATTERY POST
20944 LAPWAI                 00104 DSTA DENTAL TRAILER    47 20 B  MISSING TOOLS               $    1,000 N U 11/88 PB       C5  5 REPLACE MISSING TOOLS AT WORK STATION ON THE FORWARD END
                                                                                                                                   OF THE TRAILER

                                                               20 TOTAL $   28,620


                             IDENTIFIED DEFICIENCIES FOR: NORTHERN IDAHO

                                       TOTAL: $ 143,390
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Leroy [illegible] - Health Education
Bruce Ericson - Sanitarian
Francis [illegible] - Admin Office

ANNUAL (COMPREHENSIVE) SURVEY REPORT:

NORTHERN IDAHO INDIAN HEALTH CENTER

On March 26 1987, the survey team conducted a comprehensive Annual inspection of the Northern Idaho Indian Health Center consisting of the Lapwai Clinic and the Kamiah Tribal Center. The team members were Ed Danks, Office of Engineering Services (OES) Electrical Engineer, Danielle Earhart, OES Mechanical Engineer, Joel Matulys, OES Architect, Jim Thode, OES Civil Engineer and Dan Hightower, Chief of Facilities Services, Portland Area Office,.

Prior to beginning and during the inspection, the members consulted with Donald Bruce, Service Unit Director, and Virgil Gunn, Administrative Officer. They were very knowledgeable and helpful during the site visits and we would like to thank them for their cooperation and technical assistance. There is no Maintenance Chief, which is a major problem.

The checklist system developed by Dallas was used as the framework for the inspections, however, the checklists themselves were not included because of their size.

A more complete explanation of each deficiency is contained in the facilities work estimates (enclosure 1). The work description title from this is included in the discipline narrative to provide a checklist for coding. Where there is a major problem or concern, this title list has been expanded to provide more information to the area office.

LAPWAI HEALTH CENTER

GENERAL:

a. The Lapwai Facility is a two level, woodframe and concrete block structure of approximately 6,000 square feet. It is a relatively new structure but needs significant maintenance and repair work.

b. → After a review of the use and function of the facility and an analyses of the fire and life safety codes, we confirmed the classification as a Business Occupancy rather than the more restrictive Ambulatory Health Care category. This is consistent with the guidance contained in the NFPA 101, Life Safety Code Handbook.

o Remove office reproduction equipment & Storage items from the Mechanical Room.

c. We think it would still be very cost effective and solve many of the problems we found to provide for the annual or periodic general repair and preventive maintenance of these facilities and particularly the specialized equipment through the use of contract services. This would prevent small problems from becoming large ones and is very critical at this facility since there is no staff maintenance capability.

CIVIL:

* a. Redirect the surface water drainage which runs down the road behind the clinic.

* b. Regrade the back lawn area to drain away from and around the facility.

* c. Reseed the lawn.

* d. Plant a line of trees to the south (rear) and to the west of the clinic to provide solar protection in summer and mitigate the wind and snow drifting in winter.

ARCHITECTURAL:

Life Safety:

* a. Reroute the internal basement stairs to provide a second legal exit from the basement and to solve a serious safety problem. Insure that this stair goes directly to the outside or is protected by a 1-hour rated exit passage.

  The internal basement stairs does not qualify as an exit because it was not enclosed and forces people to re-enter the corridor once they reach the main floor. This is a serious violation of the Life Safety Code. Because of this, the only legal stair exiting from the basement is at the other end of the building so that there is, in effect, dead-end corridor which is longer than the allowable distance.

* b. Replace all unrated corridor doors with rated door assemblies and closers.

* c. Install sprinkler heads in the interstitial space above the ceiling in those rooms already provided with sprinkler heads.

* d. Provide wire safety glass in the window facing the basement exit stair.

* e. Enclose the large holes running from the mechanical room, up through the exam rooms to the attic space.

Still Some · f. Remove all stored items from corridors. This is a serious life safety threat.

HANDICAPPED:

* a. The facility meets the minimum accessibility requirements except for the toilet rooms. The patient's toilet rooms are inaccessible because of a lack of maneuvering clearance at the door and the distance between the two doors in series. These will have to be remodeled to meet accessibility requirement or the staff toilet will need to changed to accommodate this.

MAINTENANCE:

!! * a. A staff or contract maintenance person must be assigned to this facility.

* b. At the entry, eliminate the unused planter and remodel this unsightly area into a paved entry porch and sheltered area for patients. Raise this whole area up to the finished floor level to eliminate the six inch step from the entry door which is a code violation.

* c. Replace all loose or broken roof shingles.

✓ * d. Repaint the exterior of the ✓clinic and *storage building including trim, sheet metal and vents. Remove all rust from structural columns and all metal.

* e. Provide new eastside exit door and frame to the carport. Re-size the threshold to meet handicapped code.

* f. Remodel and repair the trailer and connecting breezeway by providing the following:

    1. Replace the breezeway porch and stairs and insure that new roof provides an adequate slope for drainage.
    2. Reseal the trailer roof joints, remove the rust and repaint the roof, and provide gutters and downspouts.
    3. Provide adequate locks to eliminate break-ins.

4. Replace several side panels.

✓ g. Provide local and remote burglar alarms for the facility.

h. Repair miscellaneous deficiencies in the building interior.

[illegible] i. Repaint the entire interior.

j. Provide carpeting in all corridors, waiting areas and offices.

* k. Remove the louver and patch the wall between the janitor's closet and women's toilet room and provide mechanical ventilation as necessary.

MECHANICAL

* a. Provide annual maintenance by manufacturer service representatives of the menchanical system and equipment.

* b. Provide general plumbing repair and insulation.

* c. Repair the dental lab plaster trap and plumbing.

* d. Modify the return air system.

* e. Provide for outside ventilation air (tempered).

* f. Remodel to provide the dental lab exhaust.

* g. Install exhaust ventilation for dental area.

ELECTRICAL:

* a. Replace the convenience receptacles in the basement (50).

* b. Rewire the light fixtures in the west end of the basement corridor.

* c. Remove storage from in front of the electrical panels and update the panel schedule.

* d. Add GFI protection to the receptacles above the sink.

* e. Replace the battery in the "Exit" sign in the east end of the corridor.

* f. Replace two ceiling fixtures in the main entry.

g. Cap and store wiring from the fin-tube control.

KAMIAH TRIBAL CENTER

GENERAL:

a. The facility, inspected by Dan Hightower and Jim Thode, is a trailer located in the parking lot of the Wa-A-Yaas Community Building. It includes two dental chairs, a small lab and waiting room. It is not accessible to the handicapped and has no toilet facilities.

b. This facility should be replaced by one accessible to the handicapped and containing rest room facilities.

SPECIFIC:

* a. Remove the leaking water storage tank, located in the mechanical compartment and install bypass piping.

* b. Provide regularly scheduled maintenance for the mechanical equipment located in the dental trailer.

✓ c. Provide steps and porch for the rear door to the trailer.

* d. Secure the loose metal strips in the floor plumbing access panels.

? e. Repair the light over the dental chair on the forward end of the trailer.

? f. Replace the missing dental tools at the work station on the forward end of the trailer.

? g. Replace the cracked florescent lens cover in the forward end of the trailer.

[illegible] ? h. Replace or repair the broken wall paneling in two areas.

* i. Replace the existing 1/2 inch PVC pressure and temperature relief valve discharge pipe from the electric water heater with 3/4" pipe.

* j. Replace the existing water supply line with an adequately insulated and heat traced water line to prevent future freezing.

* k. Repair or replace the inoperable exhaust fan in the darkroom and provide an exhaust duct from the grinder.

* l. Increase the lighting level in the laboratory from 22 foot candles to 100 foot candles.

m. Install skirting around the perimeter of the dental trailer.

n. Replace the missing support blocking on the front corner of the trailer.

o. Clean the corrosion from the 12 volt battery in the mechanical compartment.

p. Repair or replace the main entrance/exit door hinges.

q. Re-attach the metal trim over the door to the forward room in the dental trailer.

r. Add additional boards to the front porch railing so that there is no opening greater than six inches.

s. Paint the front porch.

SUMMARY:

A more complete explanation of the deficiencies is contained in the enclosed work estimates.

We would again like to thank the staff for their assistance.

Joel Matulys

Joel Matulys, R.A.
Team Leader

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE

COMPREHENSIVE ENVIRONMENTAL HEALTH SURVEY REPORT

LAPWAI INDIAN HEALTH CENTER
LAPWAI, IDAHO

APRIL, 1989

BY

JOHN SERY
DEPUTY ENVIRONMENTAL HEALTH SPECIALIST
PORTLAND AREA OFFICE

AND

DWAYNE D. REED, M.P.H.
SERVICE UNIT SANITARIAN
NO. IDAHO SERVICE UNIT
LAPWAI, IDAHO

INDIAN HEALTH SERVICE
ENVIRONMENTAL HEALTH SERVICES BRANCH
ENVIRONMENTAL HEALTH & ENGINEERING PROGRAM
PORTLAND, OREGON

COMPREHENSIVE ENVIRONMENTAL HEALTH SURVEY REPORT
LAPWAI HEALTH CENTER
LAPWAI, IDAHO

I. INTRODUCTION:

A comprehensive environmental health survey was conducted at the Northern Idaho Indian Health Center on April 11, 1989. The purpose of the survey was to evaluate the environmental health conditions existing at the facility and make recommendations to correct each noted problem. The Institutional Environment Control Guidelines of the Office of Environmental Health were utilized as the basis for the survey. Additional guidelines and standards are referred to at the beginning of applicable sections. The most recent environmental health survey of the facility was conducted on April 8, 1989.

The following individuals were contacted during the survey:
George Robinson - Medical Technologist
Hal Martin - Pharmacist
Carol Wheeler - Maintenance

The Health Center which employs twenty-five health professionals and serves approximately 18,000 individuals per year, is owned and operated by the U.S. Public Health Service and is located at Lapwai, Idaho, which is eleven miles south of Lewiston, Idaho. The facility consists of eleven offices, a reception area, waiting room, laboratory, pharmacy, four examination rooms, a nurses work station, four restrooms, a storage room, a two chair dental clinic, a computer room, and several small storage areas.

The following sources were used as reference and guidelines in conducting this survey:

Indian Health Service (IHS), Institutional Environment Control Guidelines, 1980.

DHHS, Guidelines for Construction and Equipment for Hospital and Medical Facilities, 1984.

Joint Commission on Accreditation of Hospitals (JCAHO), Accreditation manual for Ambulatory Health Care.

National Fire Protection Association (NFPA) Standard 101 (Life Safety Code), 1985.

II. SUMMARY

This report was submitted for the purpose of identifying Environmental Health concerns at the Northern Idaho Indian Health Center and noting corrective action taken on past deficiencies. The recommendations for correction of these findings are based on standards of the United States Public Health Service and other standards as they apply.

Priority attention should be give to developing and implementing safety and infection control policies and procedures found in sections III and IV.

It should be noted that plans have been made to construct a modular structure as an addition to the existing facility. Construction is scheduled to begin in 1989 pending approval of drawings and award of contract.

Not Done As Of 3/16/90

Many of the deficiencies cited in this report will be abated when the new addition is constructed.

Additional corrective measures should take place as time and finances become available.

At the conclusion of the survey, the findings were discussed with Frederick Baker, Service Unit Director, NISU.

III. SAFETY MANAGEMENT AND OCCUPATIONAL HEALTH

A. Program Management

The Health Center has a functional Safety Committee and quarterly meetings are chaired by the Safety Officer.

In addition, the Health Center has a functional Quality Assurance Committee. The QA policies related to inspections, drills and training are in accordance to JCAHO Ambulatory Health Care Standards, 1988. A Quality Assurance Plan (FY 1988-89) was available for the Northern Idaho Health Center.

B. Fire Safety

The National Fire Protection Association, "Life Safety Code" was utilized as the basis for Fire Safety recommendations.

An Emergency Evaluation and Fire Safety Plan (April 8, 1988) was available and quarterly fire drills were conducted, evaluated and documented.

Fire fighting support was provided by volunteers operated by the BIA and the City of Lapwai Volunteer Fire Department.

Fire suppression equipment in the Lapwai Health Center consisted of ABC type fire extinguishers for both upper and lower levels. The lower level (basement) of the clinic had a sprinkler system for the hallway, several offices, medical records room, HVAC room, and maintenance room.

COMMENTS, OBSERVATIONS, AND RECOMMENDATIONS

1. A hot-plate was noted in the maintenance room. Portable electrical space heaters were noted in several offices. Extension cords were also noted throughout the clinic. The hot-plate poses a fire hazard, and should be removed. A policy should be made for personal electrical devices, and extension cord usage. The policy should be made in accordance with all JCAHO regulations and "Life Safety Codes".

2. Fire extinguishers in the medical records office and x-ray room were not mounted off the floor in a convenient location. The fire extinguishers should be installed with the top of the extinguisher not over five feet high and in an easily accessible location near the door.

3. The fire extinguisher in the Social Services trailer needs to be labeled appropriately.

4. The fire extinguisher in the basement hallway needs to be mounted securely to the wall.

5. A fire extinguisher should be installed in the Contract Health Office because of the large amount of paper combustibles being stored there.

6. "No Smoking" signs need to be placed outside the door of the storage shed. Gasoline is stored within and poses a fire hazard. A "No Smoking" sign needs to be placed in the proximity to the propane fuel tank used for the clinic incinerator.

C. Emergency Preparedness

Internal and External Disaster Plans (April 8, 1988) were available.

An Emergency Preparedness Policy and Procedures (July 15, 1988) was available.

COMMENTS, OBSERVATIONS, RECOMMENDATIONS

Emergency drills and exercises should be incorporated into the overall Internal and External Disaster Plans and documented annually as required by the JCAHO.

D. Industrial Hygiene and Toxicology

Implementation of the OSHA Hazard Communication Standard, commonly known as the "Right To Know Law" had been initiated, (July 5, 1988) for the Health Center.

A policy and procedures to reduce, minimize and prevent the effects of hazardous materials on human health and the environment was available, (July 15, 1988).

COMMENTS, OBSERVATIONS, AND RECOMMENDATIONS

1. The eye wash bottle was not mounted or labeled properly. The eye wash bottle should be labeled and mounted for easy access. An eye wash fountain should be installed.

2. The HVAC room was cluttered, access to the circuit breaker panel was obstructed. An area needs to be cleared so that the circuit breaker panel can be accessed by all personnel.

3. The Pharmacy Store Room, which was also used as the telephone circuit room should be kept locked and secured at all times to prevent unauthorized access.

4. Cans of paint were observed in the lower cabinet of Exam Room No. 3. The paint should be removed and placed in the storage shed outside.

5. Housekeeping chemicals were being stored in the custodial room where food was prepared and eaten by employees. The custodial room was not vented. The custodial room should be vented to allow the proper exchange of air. Also, a separate room should be made available where employees can prepare and eat food.

IV. INFECTION CONTROL

All infection control matters were handled through the Quality Assurance Committee and Safety Committee. Disinfection, Sterilization, and Infection Control Policy and Procedures were available for the Dental, Laboratory, Medical and Nursing Departments.

Steam Autoclave monitoring was performed weekly for both clinic autoclaves. Records were available and kept up to date according to JCAHO standards. Results were also within the JCAHO standards.

Comments, Observations, and Recommendations

1. Bar soap was stored on a wet paper towel in the women's room on the upper level. An individual soap dispenser should be installed.

2. The examination table top in Exam Room No. 3, had tape covering a torn spot and several small tears were observed. The covering is difficult to sanitize, and therefore, should be replaced.

3. The sinks in Exam rooms No. 1 and No. 2 had no wrist blades. Wrist blades should be installed to reduce the handling of fixtures.

4. The wrist blades for the faucet in Exam room No. 3 were positioned too far back to be wrist operated. To reduce the need to operate the wrist blades by hand, the blades should be adjusted to an appropriate position.

5. Coffee cups were observed in the hand sink of the laboratory. Coffee cups should be removed and stored in a separate area to reduce the chances of contamination by accidental splashing of infectious materials.

6. Food was stored in the pharmacy drug refrigerator. Food should be removed and kept in the staffs' food refrigerator located in the basement of the center.

V. RADIATION PROTECTION

Diagnostic X-ray equipment is provided at the facility. There is one Picker medical X-ray unit and two S.S. White dental X-ray units available. George Robinson, the Medical Technologist, acts as the X-ray technologist at the facility.

A comprehensive Radiation Protection Survey of the Northern Idaho Indian Health Center, Lapwai, Idaho, was conducted on October 26, 1988 by Dr. Marshall W. Parrott, a Health Physics Consultant for the Portland Area IHS. The purpose of the survey was to evaluate the equipment and operating procedures to determine if they were appropriate for the maximum reduction in Radiation exposure associated with the use of the X-ray equipment. A copy of the survey report is attached.

The Lapwai Indian Health Center ia a participant in the USPHS Personnel Monitoring Program. Records of exposures were available and maintained by the Clinic Safety Officer. Minimal exposures were maintained.

Comments, Observations, and Recommendations

NONE

VI. SANITATION

A. Water Supply

The water supply for the health center is supplied by two wells which are operated by the City of Lapwai. The system is not chlorinated but does have fluoridation capabilities. The system is sampled for chemical and bacteriological analysis for compliance with the "Safe Drinking Water Act" (SDWA). Records were available and maintained at Lapwai City Hall. The results comply with the SDWA.

Comments, Observations, and Recommendations

NONE

B. Solid Waste

Solid waste management practices consisting of adequate storage, collection, and disposal of waste were evaluated relative to control of disease carrying vectors, elimination of accident hazards and the spread of infectious disease. Solid waste is transported to a dumpster located on the clinic compound and picked up by a contractor and transported to an Idaho County landfill near Grangeville, Idaho. Infectious waste material is incinerated daily at the clinic in a liquified petroleum gas fired incinerator, also located on the compound.

Comments, Observations, and Recommendations

1. Large rust holes were observed in the base of the dumpster. The dumpster should be replaced to eliminate rodent entry.

2. General refuse should be burned separately from infectious waste to assure that the incinerator is not overloaded.

C. Liquid Waste

All sewage generated by the facility was discharged into a community system operated by the City of Lapwai.

Comments, Observations, and Recommendations

NONE

D. Pest Control

Insect and Rodent control activities are not conducted.

Comments, Observations, and Recommendations

1. As in the past, bees are a serious problem. The services of a certified pest control operator should be procured.

2. The walls throughout the clinic had holes in various locations which could allow the entrance of insects and rodents. The holes should be sealed.

E. Housekeeping

Custodial tasks were completed by one employee. A roster of duties and activities was posted and monitored by the Administrative Officer. Documented policies and procedures were on file.

Comments, Observations, and Recommendations

1. Housekeeping equipment was stored in the corners of the HVAC room. The housekeeping equipment should be stored in an appropriate storage area used specifically for housekeeping items.

2. A mop rack in the Custodial room was being used to hang personal items. The mops and brooms were on the floor. The mop rack should be used to hang mops and brooms only.

3. Spider webs were observed in the corners of the walls at the exit door at the end of the upstairs hall. The spider web removal should be done on a regular basis as part of the daily custodial activities.

4. The sink in the X-ray room had heavy mineral crusts which should be removed.

F. Laundry

Laundry services are provided by Blue Ribbon Linen Co. and Domestic Laundry Service, both of Lewiston, Idaho.

VII. PLANT AND TECHNOLOGY

A. Structural Description

The Health Center is a one story building with a full basement constructed of cinder block and concrete. The facility was built in 1970. The basement was remodeled in 1972 and an addition was constructed in 1977 to expand the outpatient area. A trailer was placed at the north end of the clinic in 1979 to serve as offices for the Service Unit Director and the Social Worker. A new roof was installed on the Health Center in the summer of 1983. In the spring of 1986 the laboratory and X-ray facilities were moved and an additional examination room constructed. The addition of a three office trailer was accomplished in the fall of 1987 for the purpose of housing the Maternal and Child Health and Community Health Nursing Programs.

Currently, there is no maintenance person for the center. Most of the maintenance work has been done by the custodian and/or other clinical staff. The clinic is in dire need of a qualified maintenance person.

Plans have been made to construct a modular structure as an addition to the existing facility. Construction is scheduled to begin in 1989 pending budget proposals and appropriations.

Comments, Observations, and Recommendations

1. The ceiling tiles in the sanitarian's office were stained from leaking water. A large hole was also present. The ceiling tiles should be replaced and the hole repaired.

2. The exit door in the basement was scratched and rusted. Screws were loose on the panic bar support. The door should be repainted and the screws should be tightened.

3. Cover plates were needed for two electrical outlets in the Health Education office.

4. The ceiling tiles in the secretarial office were stained and sagging as a result of leaking water. The ceiling tiles should be replaced.

5. Floor tiles throughout the clinic were broken and/or cracked. The broken tiles should be replaced.

6. The ceiling tiles in the HVAC room were damaged from a past water line break and need to be replaced. A light fixture was noted to be hanging from its wires. The light fixture should be mounted securely to the ceiling.

7. The door latch for the Contract Health Office didn't latch securely and couldn't be locked. The latch should be replaced and the door kept locked to prevent unauthorized access to confidential patient records. Two electrical outlets were loose and should tightened.

8. There were no light bulbs or bulb covers for the light fixtures in the vestibule for the men's restroom (upper level) and Janitorial closet. Light bulbs and a bulb cover should be installed. The wall behind the floor sink is made of plywood and paint was peeling off. The wall should be made of a water proof material. The closet door should be kept locked to prevent unauthorized access.

9. The door handle for the Nurses Station was loose and should be tightened.

10. A light cover was missing in the front door vestibule and should be replaced. The front door panic bar latch was loose and in need of tightening. Also, the automatic closer needed adjustment and a hole was made in the wall behind the door. A door stop should be installed and the hole repaired.

11. A wall outlet in Exam Room No. 3 had no plug tension and should be replaced by a qualified electrician. A fluorescent tube was also out and there were three broken tube covers/diffusers. A fluorescent tube should be installed and the covers/diffusers replaced.

12. The exit door at the end of the hallway had no self closer. A self closing device should be installed on the door.

13. A light fixture at the end of the hallway had a missing fluorescent tube and a missing cover/diffuser. A light fixture cover outside the public restroom (rm. 117) was held into place with tape. The missing tube, cover and defective covers should be replaced.

14. The carpeting in Exam Room No. 4 was stained and in poor condition. The carpeting should be removed.

15. A light fixture in Exam Room No. 2 was out. New fluorescent tubes should be installed.

16. A cover plate for an electrical outlet needed to be attached securely in the Patient Registration room.

17. A bulb cover was missing from an incandescent light fixture in the laboratory. A light bulb cover should be installed. A base-board strip was loose and pulled away from the wall. The base-board strip should be reattached.

18. The circuit breaker panel in the WIC office was loose and should be fastened securely to the wall.

19. A light bulb was burned out in the safe light in the X-ray room. A new bulb should be installed.

20. The ceiling in the Social Services trailer was sagging and showing signs of water damage. The ceiling should be replaced and the cause of the water damage should be investigated and abated. A screen was torn and in need of replacement. The exit doors did not have self closing devices. And, the skirting around the trailer was damaged in various locations and should be repaired to prevent the harborage of animals and the accumulation of debris.

21. Downspouts/gutters for the clinic were damaged and need to be positioned so as to divert water away from the building.

B. Functional Design

The facility is a one story structure. The south end functions mainly as the medical outpatient area and the north section consists of patient registration and a patient waiting room. The dental clinic, and pharmacy are centrally located on the first floor. Contract health, the WIC program office and the administrative offices are located in the basement.

Each area of the health center was evaluated to determine the appropriateness of the functional design as it relates to handicapped requirements, location, space allocation, sanitation facilities, and other design requirements.

Comments, Observations, and Recommendations

The new addition, planned for the center, will alleviate many of the functional design deficiencies.

1. The public restrooms were not accessible to the physically handicapped. The "Minimum Guidelines and

Requirements for Standards for Accessibility and Useability of Federal and Federally Funded Buildings and Facilities by Physically handicapped Persons" should be followed for the special design features for the handicapped.

2. Increased storage space is needed for Janitorial supplies, medical supplies, and other supplies.

3. There was no multi-purpose room available for conferences, meetings, or health education. A multi-purpose room has been planned for the new addition.

4. An areas needs to be set aside in the outpatient area for wheelchair storage.

5. Increased office space was needed for the physicians. Four medical staff members were sharing the same office.

6. The basement of the clinic should be made handicapped accessible.

7. The changing room in the X-ray room was cramped and crowded and offered minimal privacy. The changing area should be enlarged to facilitate patient privacy.

8. Public restroom (Rm. 117) was very small. This restroom should be enlarged to facilitate handicapped persons. In addition, a specimen port should be installed to allow the passage of specimens directly into the laboratory without having to carry them down the hallway.

9. There was no separation or separate room for the blood draw table now located in the medical laboratory. A separate room or partition should be installed to facilitate physician and patient privacy.

10. The medical laboratory did not have a door for its entrance. An entrance door should be installed for the laboratory.

C. Plumbing

The plumbing system was evaluated to determine if it was in good working order and in compliance with the Uniform Plumbing Code.

Comments, Observations, and Recommendations

1. Plumbing leaks were found in the following areas:

   a. Womens' Restroom (cold water)
   b. Social Services trailer restroom (faucets)
   c. Drinking fountain drain in the reception area
   d. Outside water spigot

The defective plumbing should be repaired.

2. The basement drain in the HVAC room was not plumbed to accept waste water from the cooling unit and the dental department. A submerged receptacle is recommended to prevent pooling of water on the floor.

3. A drain pipe was open in the Medical records office. To prevent the entrance of gases and/or insects the pipe should be capped. The annular spaces around the pipe should be plastered and sealed.

4. The overall water temperature in the clinic was 138 degrees fahrenheit. To prevent accidental burns, the water temperature should be regulated not to exceed 110 degrees F.

D. Heating, Ventilation and Air Conditioning (HVAC)

Heat was provided by a heat pump supplemented by an electric furnace. The trailer is electrically heated.

The Indian Health Service HVAC Design Criteria was used as the standard during the evaluation of the ventilation system The health station was ventilated by electrical and natural means.

The facility was cooled by the heat pump system.

Comments, Observations, and Recommendations

1. Heat was inadequate in some areas of the basement. A

heating system professional should be hired to evaluate the system. The system should be capable of maintaining a temperature of at least 72 degrees fahrenheit in all areas.

2. An exhaust port in the janitorial closet exhausted air into the womens' restroom. All air from the janitors closet must be exhausted directly to the outdoors. An exhaust system capable of providing a minimum of 10 air changes per hour should be installed.

3. The ventilation system in the laboratory was non-existent. The ventilation in the Dental laboratory was inadequate. Both laboratories are required to be under negative pressure and served by a ventilation system capable of supplying a minimum of 6 air changes per hour and with all air being exhausted directly to the outdoors.

4. There was no exhaust hood available in the dental or medical laboratories. Exhaust hoods should be installed in these locations for the safety of employees that are handling infectious or hazardous materials.

5. There was no exhaust vent for the Janitorial closet in the basement (Also used as the staff lounge). An exhaust system vented to the outdoors should be installed to provide a minimum of 10 air changes per hour.

F. Electrical/Lighting

Battery powered emergency lighting was provided in the event of a power failure. The health center was not powered with a source of emergency power.

Lighting levels were measured with a General Electric Type 214 light meter, and were evaluated on the basis of available artificial and natural lighting and the intended use of the area.

Comments, Observations, and Recommendations

Electrical

--In general, all electrical outlets with their grounds at the top of the plugs, had reversed polarity. This was observed throughout the clinic.

--All electrical deficiencies should be serviced by a certified electrician.

1. Two electrical outlets in the Health Education office had open grounds.

2. One electrical outlet in the patient registration office had an open ground.

3. Several electrical outlets in the Nurses Station had reversed polarity.

4. One electrical outlet in Exam Room No. 4 had an open ground. Two reversed polarity outlets were also observed. A defective cord (taped) for a Welch Allyn transformer was observed. Exposed wires with bare ends were observed protruding form a junction box behind the examination table.

5. One electrical outlet in Exam Room No. 1 had an open ground. One outlet was loose. Two outlets had possible open grounds - The test light flickered when plugged into them. One fluorescent light also flickered when turned on.

6. Several electrical outlets in the X-ray room had reversed polarity.

7. An exit light at the South end of the clinic was wired to the wall switch that controls the hallway lights. The light should be wired so as to allow it to remain on at all times.

8. An electrical outlet was damaged in the Social Services trailer. The electrical wiring was exposed. An extension cord plugged into another trailer was used as the electrical source for a water line heat tape. The tape should be plugged directly into an outlet (The use of extension cords in place of permanent wiring is prohibited).

9. Circuit breaker #13 in the WIC office breaker panel overloads easily. The #13 Breaker is not listed on the circuit directory. The Directory is not accurate and needs to be properly labeled. The reason for the overload should be checked by a certified electrician.

10. Light levels needed to be icreased as follows:

Lighting	Ft. Candles	Recomm. level
Secretarial Desk	42 Fc.	50 Fc.
Contract Health typing	48 Fc.	50 Fc.
WIC office Desk	40 Fc.	50 Fc.
Pharmacy (Storeroom)	10 Fc.	30 Fc.
(counter/worktable)	60 Fc.	100 Fc.
Medical Supply Room	10 Fc.	30 Fc.
Medical Chart Rack	34 Fc.	70 Fc.
Receptionist Desk	48 Fc.	50 Fc.
Nurses station (writing)	50 Fc.	70 Fc.
Nurses station Exam table	60 Fc.	100 Fc.
(typing)	28 Fc.	70 Fc.
Exam Room No. 1 (table)	70 Fc.	100 Fc.
Exam Room No. 2 (table)	50 Fc.	100 Fc.
Exam Room No. 3 (table)	36 Fc.	100 Fc.
(defibrillator)	70 Fc.	100 Fc.
Exam Room No. 4 (Table)	80 Fc.	100 Fc.
Dental (writing surface)	40 Fc.	70 Fc.

VIII. CONCLUSION

The writer wishes to thank the staff for their cooperation and courtesy shown during the survey.

Submitted by: Dwayne D Reed 6-16-89
Dwayne D. Reed, M.P.H. Date
Service Unit Sanitarian
No. Idaho Service Unit

Reviewed by: Frederick B. Baker 6/16/89
Frederick Baker Date
Health Systems Administrator
No. Idaho Service Unit

Reviewed by: John G. Sery 6/27/89
John Sery, Deputy, EH Specialist Date
Portland Area Indian Health Service

Reviewed by: 6/27/89
Ted Ziegler, EH Specialist Date
Portland Area Indian Health Service

DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service

Memorandum

Date DEC 5 1988

From Director
Portland Area Indian Health Service

Subject Phase I Scores, Health Facility Construction Priority System

To Director, Division of Facilities Planning and Construction
Indian Health Service Headquarters

Attached are the Phase I facility scores calculated by the new methodology for sites identified in the Portland Area Health Facilities Master Plan. The planning staff has followed as closely as possible the directions in the September 2 memo from the Deputy Director. The methodology was applied to FY 1987 workload data at the sites in question but the logic train of the forms appeared to be faulty when facilities were proposed in locations without existing clinics and an alternate score was calculated. The logic and justification employed in arriving at these alternative scores is fully explained in the narrative accompanying each site.

We are not submitting the requested scale drawings of existing facilities at this time. Our material was badly outdated and we have contracted for field measurements and scale drawings of the facilities as they currently function. This contract is expected to be completed by late January which should be sufficient time for any necessary Phase II verification studies .

Service Unit	Facility	Phase I Score
1) Puget Sound	Tulalip HC	65.71 *
2) Colville	Omak HC	63.61 *
3) Warm Springs	Klamath HC	45.90 *
4) Colville	Inchelium HC	38.69 *
5) Northern Idaho	Lapwai HC	29.70
6) Warm Springs	Warm Springs HC	13.01
7) Colville	Nespelem HC	-10.50
8) Taholah	Taholah HC	-22.79
9) Wellpinit	Wellpinit HC	-23.64

* Note special justification in narrative.

Please contact the planning branch in Portland if clarification is needed on these submissions.

Terrence S. Batliner
Terrence S. Batliner, D.D.S.

Justification: Phase I Facility Priority Scores

Tulalip:

During FY 1987, Tulalip tribal members received direct health care services from two physician extenders in an outmoded trailer. The total workload (direct and contract) for that year totaled 7,731 PCPVs, or a 3.36 PCPV/person rate based on our estimated active population of 2,300. Portland Area planning staff assumes that if an adequately designed and staffed ambulatory clinic were available in this location, the vast majority of the current CHS workload would convert to direct care. Only 15% of the total workload (or 1,160 PCPVs) would remain in CHS being accounted for in specialty, referral and emergency care that would be unavailable at this proposed clinic.

The Phase I HFCPS score of 65.71 is based on the assumption that 6,571 PCPVs will be provided at the proposed facility and 1,160 actual visits will be provided by CHS.

Omak:

The FY 1987 total workload of 7,483 PCPVs by the 1,556 accessible users represents a utilization rate of 4.8 PCPVs per person. Over 90% of these visits are provided by CHS. Were an adequately designed and staffed direct care facility to become a reality in this community, planning staff estimates that 85% of the total workload would be able to be provided by the direct care staff.

The Phase I HFCPS score of 63.61 is based on the assumption that 6,361 PCPVs will be provided at the proposed facility and 1,122 actual visits will be provided by CHS.

Klamath:

The FY 1987 total workload of 2,828 PCPVs by the estimated 1,800 accessible users is over 99% contract. It seems remarkable that nearly 80% of the estimated Indian census population of this county has registered for services in spite of a complete lack of outreach staff. We attribute this to an excellent health assessment being conducted by the tribe pursuant to restoration of tribal status. Planning staff proposes to combine our population estimate of 1,800 with the minimum utilization rate of 3.0 PCPVs/person to arrive at the correct HFCPS score.

The Phase I HFCPS score of 45.90 is based on the assumption that 4,590 visits will be provided direct and 810 actual visits (15% of total 5,400 PCPV workload) will be provided via the CHS mechanism.

Inchelium:

The FY 1987 workload at the Inchelium facility presents an inaccurate picture of the potential for direct health care services in this location. The direct visits for FY 1988 will probably be 20% greater than in FY 1987 in spite of a skeleton staff of three employees and a clinic space of less than 500 NSF. The active registrant tabulation of 610 is far below the currently shown accessible population of 933. We propose to use a PCPV rate of 4.9 calculated from the total FY 1987 workload of 4,552 PCPVs (direct and contract) and the more accurate 933 registration figure.

The Phase I HFCPS score of 38.69 is based on the assumption that 3,869 visits will be provided direct and 682 actual visits (15% of the total PCPV workload) will be provided via the CHS mechanism. This is thought to be a conservative estimate considering the isolation of this community and the dramatic increases in direct workload now being observed.

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           Portland Area IHS Construction Priority System
                       FACILITY DATA FORM
                Ambulatory Health Care Facilities

==========================================================================

      IHS SERVICE UNIT.................................PUGET SOUND

      FACILITY LOCATION:.......................................Tulalip

      PRIORITY SCORE:.................................       47.50
==========================================================================
                  DRIVING VARIABLES
  Primary Care Provider (PCP) Visit Rate  (Lower Limit)          3.00
  Primary Care Provider (PCP) Visit Rate  (Upper Limit)          6.10

  Current PCP VISIT RATE for Facility.........................   3.36
  Accessible USER POPULATION for current year.................  2,300

  EXISTING FACILITY (?)   (0=No  1=Yes).......................      0

  HANSCOMB'S COST per Sq Ft to Build New......................     $0

                   CURRENT WORKLOAD
  DIRECT PCPVs by Accessible Users to Facility................  3,711
  DIRECT PCPVs by Accessible Users to Neighbouring Facility...     45
  DIRECT PCPVs to Facility by INACCESSIBLE USERS..............      0
  Contract (CHS) PCPVs by Accessible Users....................  3,975

                CURRENT FACILITY SPACE
  Facility Gross Sq Ft........................................      0

                  FACILITY EVALUATION
  Legal/Code Deficiencies   (FEDS Codes 2,3,4,7 & 8)..........     $0
  BEMAR Deficiencies   (FEDS Codes 11,12,13,14 & 15)..........     $0
  Medicare, Medicaid, JCAHO Identified Deficiencies...........     $0
==========================================================================
                  CALCULATED INDEXES
  TOTAL PCPVs by ACCESSIBLE USERS.............................  7,731
  PCPVs to Facility...........................................  4,750
  Adjusted PCPVs..............................................  4,750
  Base Demand Score...........................................  47.50
  Cost per Sq Ft to REPAIR....................................    ERR
  Existing Space Adjustment Factor............................    ERR
  Required Space..............................................  2,425
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            Portland Area IHS Construction Priority System
                          FACILITY DATA FORM
                 Ambulatory Health Care Facilities

=======================================================================

        IHS SERVICE UNIT.......................................COLVILLE

        FACILITY LOCATION:.........................................Omak

        PRIORITY SCORE:....................................     24.83
=======================================================================
                    DRIVING VARIABLES
  Primary Care Provider (PCP) Visit Rate  (Lower Limit)          3.00
  Primary Care Provider (PCP) Visit Rate  (Upper Limit)          6.10

  Current PCP VISIT RATE for Facility.........................   4.81
  Accessible USER POPULATION for current year.................  1,556

  EXISTING FACILITY (?)   (0=No  1=Yes).......................      0

  HANSCOMB'S COST per Sq Ft to Build New......................     $0

                    CURRENT WORKLOAD
  DIRECT PCPVs by Accessible Users to Facility................    177
  DIRECT PCPVs by Accessible Users to Neighbouring Facility...    639
  DIRECT PCPVs to Facility by INACCESSIBLE USERS..............      0
  Contract (CHS) PCPVs by Accessible Users....................  6,667

                  CURRENT FACILITY SPACE
  Facility Gross Sq Ft........................................      0

                   FACILITY EVALUATION
  Legal/Code Deficiencies   (FEDS Codes 2,3,4,7 & 8)..........     $0
  BEMAR Deficiencies   (FEDS Codes 11,12,13,14 & 15)..........     $0
  Medicare, Medicaid, JCAHO Identified Deficiencies...........     $0
=======================================================================
                   CALCULATED INDEXES
  TOTAL PCPVs by ACCESSIBLE USERS.............................  7,483
  PCPVs to Facility...........................................  2,483
  Adjusted PCPVs..............................................  2,483
  Base Demand Score...........................................  24.83
  Cost per Sq Ft to REPAIR....................................    ERR
  Existing Space Adjustment Factor............................    ERR
  Required Space..............................................  1,745
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30-Nov-88

Portland Area IHS Construction Priority System
FACILITY DATA FORM
Ambulatory Health Care Facilities

IHS SERVICE UNIT	WARM SPRINGS
FACILITY LOCATION:	Klamath
PRIORITY SCORE:	32.96

DRIVING VARIABLES

Primary Care Provider (PCP) Visit Rate (Lower Limit)	3.00
Primary Care Provider (PCP) Visit Rate (Upper Limit)	6.10
Current PCP VISIT RATE for Facility	1.57
Accessible USER POPULATION for current year	1,800
EXISTING FACILITY (?) (0=No 1=Yes)	0
HANSCOMB'S COST per Sq Ft to Build New	$0

CURRENT WORKLOAD

DIRECT PCPVs by Accessible Users to Facility	0
DIRECT PCPVs by Accessible Users to Neighbouring Facility	22
DIRECT PCPVs to Facility by INACCESSIBLE USERS	0
Contract (CHS) PCPVs by Accessible Users	2,806

CURRENT FACILITY SPACE

Facility Gross Sq Ft	0

FACILITY EVALUATION

Legal/Code Deficiencies (FEDS Codes 2,3,4,7 & 8)	$0
BEMAR Deficiencies (FEDS Codes 11,12,13,14 & 15)	$0
Medicare, Medicaid, JCAHO Identified Deficiencies	$0

CALCULATED INDEXES

TOTAL PCPVs by ACCESSIBLE USERS	2,828
PCPVs to Facility	724
Adjusted PCPVs	3,296
Base Demand Score	32.96
Cost per Sq Ft to REPAIR	ERR
Existing Space Adjustment Factor	ERR
Required Space	1,989

HFCPSInc

30-Nov-88

Portland Area IHS Construction Priority System
FACILITY DATA FORM
Ambulatory Health Care Facilities

IHS SERVICE UNIT	COLVILLE
FACILITY LOCATION:	Inchelium
PRIORITY SCORE:	27.02

DRIVING VARIABLES

Primary Care Provider (PCP) Visit Rate (Lower Limit)	3.00
Primary Care Provider (PCP) Visit Rate (Upper Limit)	6.10
Current PCP VISIT RATE for Facility	7.47
Accessible USER POPULATION for current year	610
EXISTING FACILITY (?) (0=No 1=Yes)	0
HANSCOMB'S COST per Sq Ft to Build New	$0

CURRENT WORKLOAD

DIRECT PCPVs by Accessible Users to Facility	3,194
DIRECT PCPVs by Accessible Users to Neighbouring Facility	6
DIRECT PCPVs to Facility by INACCESSIBLE USERS	0
Contract (CHS) PCPVs by Accessible Users	1,358

CURRENT FACILITY SPACE

Facility Gross Sq Ft	0

FACILITY EVALUATION

Legal/Code Deficiencies (FEDS Codes 2,3,4,7 & 8)	$0
BEMAR Deficiencies (FEDS Codes 11,12,13,14 & 15)	$0
Medicare, Medicaid, JCAHO Identified Deficiencies	$0

CALCULATED INDEXES

TOTAL PCPVs by ACCESSIBLE USERS	4,558
PCPVs to Facility	3,540
Adjusted PCPVs	2,703
Base Demand Score	27.02
Cost per Sq Ft to REPAIR	ERR
Existing Space Adjustment Factor	ERR
Required Space	1,811

HFCPSLap

30-Nov-88

Portland Area IHS Construction Priority System
FACILITY DATA FORM
Ambulatory Health Care Facilities

IHS SERVICE UNIT	NORTHERN IDAHO
FACILITY LOCATION:	Lapwai
PRIORITY SCORE:	29.70

DRIVING VARIABLES

Primary Care Provider (PCP) Visit Rate (Lower Limit)	3.00
Primary Care Provider (PCP) Visit Rate (Upper Limit)	6.10
Current PCP VISIT RATE for Facility	4.57
Accessible USER POPULATION for current year	2,080
EXISTING FACILITY (?) (0=No 1=Yes)	1
HANSCOMB'S COST per Sq Ft to Build New	$105

CURRENT WORKLOAD

DIRECT PCPVs by Accessible Users to Facility	8,199
DIRECT PCPVs by Accessible Users to Neighbouring Facility	22
DIRECT PCPVs to Facility by INACCESSIBLE USERS	349
Contract (CHS) PCPVs by Accessible Users	1,287

CURRENT FACILITY SPACE

Facility Gross Sq Ft.	5,951

FACILITY EVALUATION

Legal/Code Deficiencies (FEDS Codes 2,3,4,7 & 8)	$57,060
BEMAR Deficiencies (FEDS Codes 11,12,13,14 & 15)	$54,870
Medicare, Medicaid, JCAHO Identified Deficiencies	$0

CALCULATED INDEXES

TOTAL PCPVs by ACCESSIBLE USERS	9,508
PCPVs to Facility	8,892
Adjusted PCPVs	8,892
Base Demand Score	88.92
Cost per Sq Ft to REPAIR	$19
Existing Space Adjustment Factor	0.18
Required Space	3,668

HFCPSWS

30-Nov-88

Portland Area IHS Construction Priority System
FACILITY DATA FORM
Ambulatory Health Care Facilities

IHS SERVICE UNIT	WARM SPRINGS
FACILITY LOCATION:	Warm Springs
PRIORITY SCORE:	13.01

DRIVING VARIABLES

Primary Care Provider (PCP) Visit Rate (Lower Limit)	3.00
Primary Care Provider (PCP) Visit Rate (Upper Limit)	6.10
Current PCP VISIT RATE for Facility	5.26
Accessible USER POPULATION for current year	2,921
EXISTING FACILITY (?) (0=No 1=Yes)	1
HANSCOMB'S COST per Sq Ft to Build New	$108

CURRENT WORKLOAD

DIRECT PCPVs by Accessible Users to Facility	14,317
DIRECT PCPVs by Accessible Users to Neighbouring Facility	117
DIRECT PCPVs to Facility by INACCESSIBLE USERS	870
Contract (CHS) PCPVs by Accessible Users	927

CURRENT FACILITY SPACE

Facility Gross Sq Ft	14,337

FACILITY EVALUATION

Legal/Code Deficiencies (FEDS Codes 2,3,4,7 & 8)	$70,200
BEMAR Deficiencies (FEDS Codes 11,12,13,14 & 15)	$357,900
Medicare, Medicaid, JCAHO Identified Deficiencies	$0

CALCULATED INDEXES

TOTAL PCPVs by ACCESSIBLE USERS	15,361
PCPVs to Facility	15,536
Adjusted PCPVs	15,536
Base Demand Score	155.36
Cost per Sq Ft to REPAIR	$30
Existing Space Adjustment Factor	0.28
Required Space	5,661

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30-Nov-88

Portland Area IHS Construction Priority System
FACILITY DATA FORM
Ambulatory Health Care Facilities

IHS SERVICE UNIT	COLVILLE
FACILITY LOCATION:	Nespelem
PRIORITY SCORE:	-10.50

DRIVING VARIABLES

Primary Care Provider (PCP) Visit Rate (Lower Limit)	3.00
Primary Care Provider (PCP) Visit Rate (Upper Limit)	6.10
Current PCP VISIT RATE for Facility	7.29
Accessible USER POPULATION for current year	1,639
EXISTING FACILITY (?) (0=No 1=Yes)	1
HANSCOMB'S COST per Sq Ft to Build New	$111

CURRENT WORKLOAD

DIRECT PCPVs by Accessible Users to Facility	9,137
DIRECT PCPVs by Accessible Users to Neighbouring Facility	75
DIRECT PCPVs to Facility by INACCESSIBLE USERS	152
Contract (CHS) PCPVs by Accessible Users	2,743

CURRENT FACILITY SPACE

Facility Gross Sq Ft	17,010

FACILITY EVALUATION

Legal/Code Deficiencies (FEDS Codes 2,3,4,7 & 8)	$365,250
BEMAR Deficiencies (FEDS Codes 11,12,13,14 & 15)	$663,120
Medicare, Medicaid, JCAHO Identified Deficiencies	$0

CALCULATED INDEXES

TOTAL PCPVs by ACCESSIBLE USERS	11,955
PCPVs to Facility	10,050
Adjusted PCPVs	8,093
Base Demand Score	80.93
Cost per Sq Ft to REPAIR	$60
Existing Space Adjustment Factor	0.54
Required Space	3,428

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            Portland Area IHS Construction Priority System
                          FACILITY DATA FORM
                   Ambulatory Health Care Facilities

===========================================================================

      IHS SERVICE UNIT.......................................TAHOLAH

      FACILITY LOCATION:.....................................Taholah

      PRIORITY SCORE:....................................    -22.79
===========================================================================
                    DRIVING VARIABLES
 Primary Care Provider (PCP) Visit Rate  (Lower Limit)           3.00
 Primary Care Provider (PCP) Visit Rate  (Upper Limit)           6.10

 Current PCP VISIT RATE for Facility......................       6.54
 Accessible USER POPULATION for current year..............      1,393

 EXISTING FACILITY (?)   (0=No  1=Yes)....................          1

 HANSCOMB'S COST per Sq Ft to Build New...................       $103

                    CURRENT WORKLOAD
 DIRECT PCPVs by Accessible Users to Facility.............      7,490
 DIRECT PCPVs by Accessible Users to Neighbouring Facility...      44
 DIRECT PCPVs to Facility by INACCESSIBLE USERS...........         55
 Contract (CHS) PCPVs by Accessible Users.................      1,573

                 CURRENT FACILITY SPACE
 Facility Gross Sq Ft.....................................      9,191

                  FACILITY EVALUATION
 Legal/Code Deficiencies   (FEDS Codes 2,3,4,7 & 8)..........  $35,700
 BEMAR Deficiencies   (FEDS Codes 11,12,13,14 & 15)..........  $44,840
 Medicare, Medicaid, JCAHO Identified Deficiencies...........       $0
===========================================================================
                   CALCULATED INDEXES
 TOTAL PCPVs by ACCESSIBLE USERS..........................      9,107
 PCPVs to Facility........................................      7,982
 Adjusted PCPVs...........................................      7,373
 Base Demand Score........................................      73.73
 Cost per Sq Ft to REPAIR.................................         $9
 Existing Space Adjustment Factor.........................       0.09
 Required Space...........................................      3,212
```

HFCPSwel

30-Nov-88

Portland Area IHS Construction Priority System
FACILITY DATA FORM
Ambulatory Health Care Facilities

IHS SERVICE UNIT	WELLPINIT
FACILITY LOCATION:	Wellpinit
PRIORITY SCORE:	-23.64

DRIVING VARIABLES

Primary Care Provider (PCP) Visit Rate (Lower Limit)	3.00
Primary Care Provider (PCP) Visit Rate (Upper Limit)	6.10
Current PCP VISIT RATE for Facility	4.96
Accessible USER POPULATION for current year	1,705
EXISTING FACILITY (?) (0=No 1=Yes)	1
HANSCOMB'S COST per Sq Ft to Build New	$107

CURRENT WORKLOAD

DIRECT PCPVs by Accessible Users to Facility	7,731
DIRECT PCPVs by Accessible Users to Neighbouring Facility	50
DIRECT PCPVs to Facility by INACCESSIBLE USERS	218
Contract (CHS) PCPVs by Accessible Users	681

CURRENT FACILITY SPACE

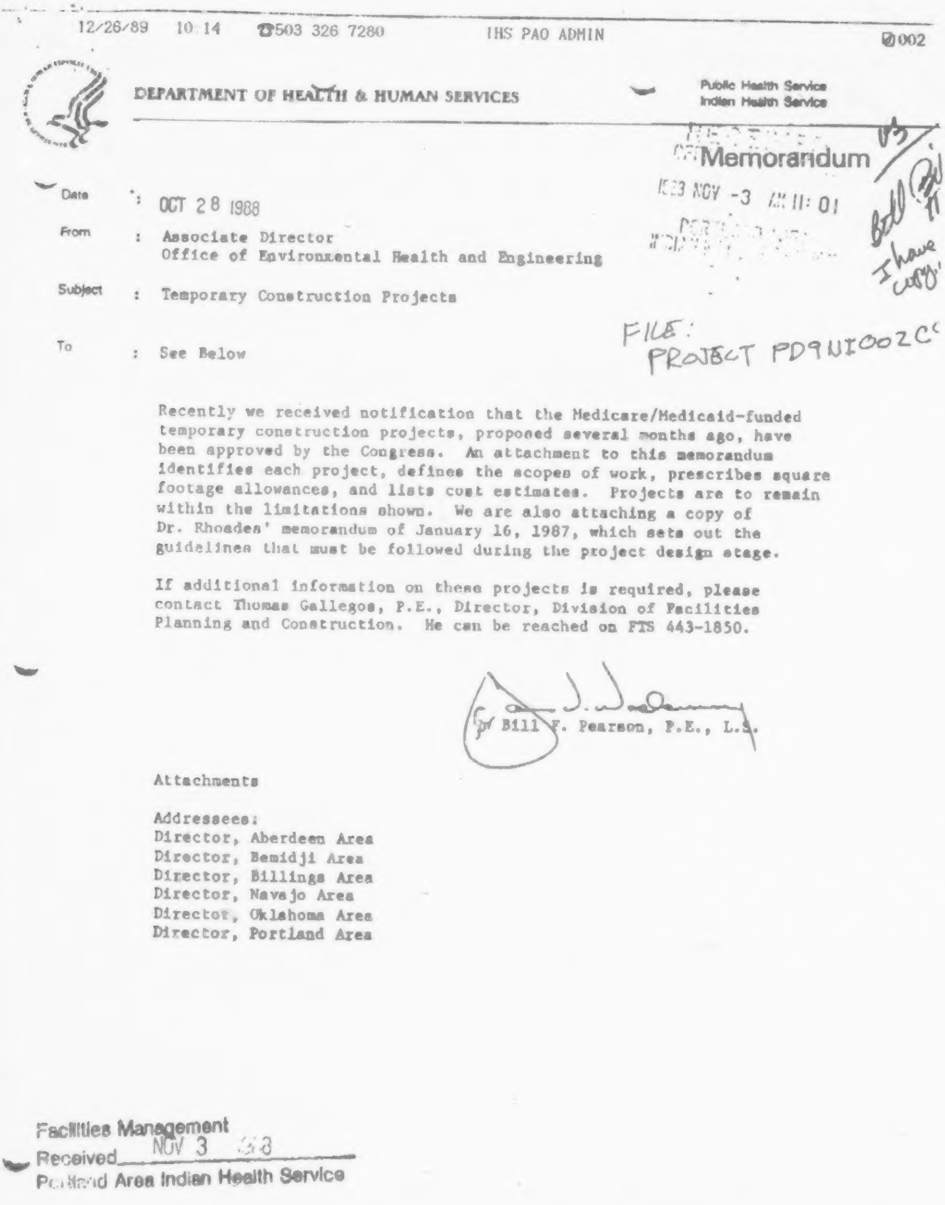
Facility Gross Sq Ft	10,002

FACILITY EVALUATION

Legal/Code Deficiencies (FEDS Codes 2,3,4,7 & 8)	$95,550
BEMAR Deficiencies (FEDS Codes 11,12,13,14 & 15)	$22,500
Medicare, Medicaid, JCAHO Identified Deficiencies	$0

CALCULATED INDEXES

TOTAL PCPVs by ACCESSIBLE USERS	8,462
PCPVs to Facility	8,169
Adjusted PCPVs	8,169
Base Demand Score	81.69
Cost per Sq Ft to REPAIR	$12
Existing Space Adjustment Factor	0.11
Required Space	3,451



12/26/89 10:14 ☎503 326 7280 IHS PAO ADMIN 002

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Indian Health Service

Memorandum

1988 NOV -3 AM 11:01

03

Bill

I have copy

Date : OCT 28 1988

From : Associate Director
Office of Environmental Health and Engineering

Subject : Temporary Construction Projects

To : See Below

FILE:
PROJECT PD9NI002C

Recently we received notification that the Medicare/Medicaid-funded temporary construction projects, proposed several months ago, have been approved by the Congress. An attachment to this memorandum identifies each project, defines the scopes of work, prescribes square footage allowances, and lists cost estimates. Projects are to remain within the limitations shown. We are also attaching a copy of Dr. Rhoades' memorandum of January 16, 1987, which sets out the guidelines that must be followed during the project design stage.

If additional information on these projects is required, please contact Thomas Gallegos, P.E., Director, Division of Facilities Planning and Construction. He can be reached on FTS 443-1850.

for Bill F. Pearson, P.E., L.S.

Attachments

Addressees:
Director, Aberdeen Area
Director, Bemidji Area
Director, Billings Area
Director, Navajo Area
Director, Oklahoma Area
Director, Portland Area

Facilities Management
Received NOV 3 1988
Portland Area Indian Health Service

MEDICARE/MEDICAID SPACE UTILIZATION NEEDS

ABERDEEN AREA

a. Belcourt. In order to meet Joint Commission standards for adequate and appropriate storage facilities for bulk stores, an additional 2,500 gross square feet of storage space is required.

The current practice of using the housekeeping area and hallways to store supplies and equipment must be eliminated. It has been determined that the additional 2,500 square feet is the minimum size temporary building that will correct the deficiency.

COST: $189,550

Cost Breakdown:	Building Cost	$155,000
	Site development	$7,750
	Design	$9,300
	Equipment	$17,500

b. Pine Ridge. The existing optometry clinic of Pine Ridge does not have the space required to effectively and efficiently fulfill its mission and presently does not meet the physical facility space standards of the Council on Clinical Optometric Care. To provide adequate space for this clinic, an additional 900 gross square feet of space is required.

COST: $107,940

Cost Breakdown:	Building Cost	$54,000
	Site development	$2,700
	Design	$3,240
	Equipment	$48,000

c. Rapid City. In a recent survey by the CAP, 37 space-related deficiencies were identified for correction to maintain CAP accreditation. To meet this need, the addition of approximately 800 gross square feet of temporary space is proposed. This space will allow the separation of general chemistry from the rest of the laboratory. It will also provide separate space for the bacteriology laboratory. Both of these functions require separate space to keep from contaminating specimens and causing laboratory results to be less than accurate. Included in the project is the necessary renovation to make the addition workable.

COST: $200,100

Cost Breakdown:	Building Cost	$139,200
	Site Development	$7,500
	Design	$8,400
	Equipment	$45,000

BEMIDJI AREA

Cass Lake. Joint Commission standards require sufficient space for the radiology department to perform its function effectively and safely. The radiology department of this hospital does not meet the minimum requirements for space. It has been determined that 2,000 gross square feet of additional temporary space is required. The temporary space will be constructed adjacent to the existing x-ray department and will house the film processor, film storage, patient waiting area, and technician office. This will alleviate patients waiting in the corridor and film being stored in the corridor.

COST: $250,000

Cost Breakdown:	Building Cost	$190,000
	Site Development	$25,000
	Design	$18,000
	Equipment	$17,000

BILLINGS AREA

a. Lame Deer.

(1) Joint Commission ambulatory care standards require adequate space to store supplies and equipment for ambulatory care centers. The present facility does not have adequate storage space for all of its supplies. The present practice to use janitor closets and other unacceptable space must be changed if the facility is to meet the minimum standards set by the Joint Commission for ambulatory care centers. In order to meet this need, the Lame Deer, Montana, Indian Health Center needs approximately 3,000 gross square feet of temporary additional space to correct this deficiency.

COST: $150,000

Cost Breakdown:	Building Cost	$135,000
	Site Development	$6,000
	Design	$8,000
	Equipment	$1,000

(2) Joint Commission ambulatory care standards require adequate space to perform maintenance functions in an ambulatory care health facility. A 50-year-old tribally owned Quonset building presently used for maintenance needs to be replaced because of its deteriorated condition and the plan to demolish the building. It has been determined that a temporary construction facility of 2,000 gross square feet, will adequately replace the obsolete 50-year-old tribal Quonset building presently used for maintenance functions at Lame Deer.

COST: $100,000

Cost Breakdown:	Building Cost	$93,500
	Site Development	$2,000
	Design	$4,000
	Equipment	$500

b. Rocky Boy's. Rocky Boy's Health Center has inadequate space for its emergency and examination rooms. It also has inadequate space to support Health Center operations. A recent Joint Commission survey of this facility cited it for deficient space in the emergency room, examination rooms, and storage space for supplies and equipment. It has been determined that to meet the minimum square footage requirements to correct these deficiencies approximately 2,860 additional gross square feet is needed. This will be corrected by the use of a temporary addition.

COST: $239,000

Cost Breakdown:	Building Cost	$208,000
	Site Development	$10,000
	Design	$13,500
	Equipment	$7,500

NAVAJO AREA

a. Gallup.

(1) The Joint Commission survey has declared the Gallup Indian Medical Center's Paint Shop obsolete and unsafe. The construction of a temporary insulated metal building to house this paint shop is proposed for 2,000 gross square feet. Construction of this temporary building will correct the deficiency that was cited by the Joint Commission.

COST: $90,000

Cost Breakdown:	Building Cost	$55,000
	Site Development	$35,000
	Design	$0
	Equipment	$0

(2) The Joint Commission has cited the Gallup Indian Medical Center for inadequate storage area for clean and soiled linen. This is a violation of infection control procedures of the hospital. It is a situation that can cause cross-contamination of clean linen. This condition must be corrected to prevent the possibility of hospital-acquired infections. In order to provide for an adequate separated storage area for clean and soiled linen, temporary construction of 4,400 gross square feet is proposed for the Gallup Indian Medical Center.

COST: $160,000

Cost Breakdown:	Building Cost	$80,000
	Site Development	$70,000
	Design	$10,000
	Equipment	$0

b. Winslow. The Winslow Indian Health Center does not meet Joint Commission standards for adequate space for pathology and medical laboratory services. An additional 1,440 gross square feet of additional temporary space is required to correct this deficiency.

COST: $250,000

Cost Breakdown:	Building Cost	$216,000
	Site Development	$15,000
	Design	$15,000
	Equipment	$4,000

OKLAHOMA CITY AREA

a. Claremore. A recent Joint Commission survey of Claremore Hospital found the emergency service area at this hospital did not have adequate space to provide effective care for emergency patients. It has been determined that approximately 2,500 gross square feet of additional temporary space is required to correct this deficiency. The temporary space will house a waiting area, triage, bathrooms, exam rooms, and observation rooms to treat approximately 30,000 patients annually.

COST: $250,000

Cost Breakdown:	Building Cost	$160,000
	Site Development	$5,000
	Design	$10,000
	Equipment	$75,000

b. Clinton. A recent Joint Commission survey of Clinton Hospital identified a shortage of space for its ambulatory care service area. Specifically, the Joint Commission cited the facility for inadequate waiting area with insufficient seating. In addition the facility was cited for lack of patient privacy. The Joint Commission stated the outpatient area is cramped, crowded, and inadequate for patient population. Approximately 2,500 gross square feet of additional temporary space is required to correct this deficiency.

COST: $249,000

Cost Breakdown:	Building Cost	$210,000
	Site Development	$4,000
	Design	$20,000
	Equipment	$15,000

c. Lawton. A recent Joint Commission survey of the Lawton Hospital identified a shortage of space for the pharmacy as well as the obstetrics/gynecology and pediatric clinic. The survey states that adequate ambulatory care areas which enable the effective management of patient care must be provided. It has been determined that approximately 2,500 gross square feet of additional temporary space is required to correct these deficiencies.

COST: $249,000

Cost Breakdown:	Building Cost	$210,000
	Site Development	$4,000
	Design	$20,000
	Equipment	$15,000

PORTLAND AREA

Lapwai, Idaho. The present clinic has serious space deficiencies in all categories. It has been determined that 2,940 gross square feet of temporary space which will house the dental program will allow the remainder of the clinic operations to reorganize into a more efficient operation and will give the medical program more space. → This temporary space will resolve a critical problem until the facility is replaced in the normal permanent construction cycle. The cost is estimated to be $249,130. (Note: One thousand fifty-six gross square feet was approved in the FY 84 submission but the scope was inadequate to meet the actual requirements; hence. a new submission in this group.)

COST: $249,130

Cost Breakdown:	Building Cost	$172,530
	Site Development	$46,600
	Design	$5,000
	Equipment	$25,000

SENT BY:Nez Perce ; 9-19-90 1:44PM ; 2088432036→ 2025447716;# 2

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

NORTHERN IDAHO SERVICE UN
P.O. DRAWER #367
LAPWAI, IDAHO 83540
PHONE: 208-843-2271

H&C Sub Chair
Mike Penney

FOR YOUR INFORMATION &/or ACTION
from Allen V. Pinkham 1/24/90
date
initials glu

January 23, 1990

JAN 24 1990

Allen V. Pinkham, Chairman
Nez Perce Tribal Executive Committee
P. O. Box 305
Lapwai, Idaho 83540

Dear Mr. Pinkham:

This is in reply to your request to hold up the "Temporary Addition" project for six weeks to allow some time to work on a replacement facility for the Lapwai Health Center.

I discussed the request with the planning office and the facilities management office at our Portland Area Office. Both staffs at these offices agreed very strongly that the chances of getting on the construction priority list were "so slim" that we should not jeopardize the present plans by any type of delay.

Therefore, the project is still going ahead as planned. If you wish to discuss this in greater detail, please call me. Thank you.

Sincerely,

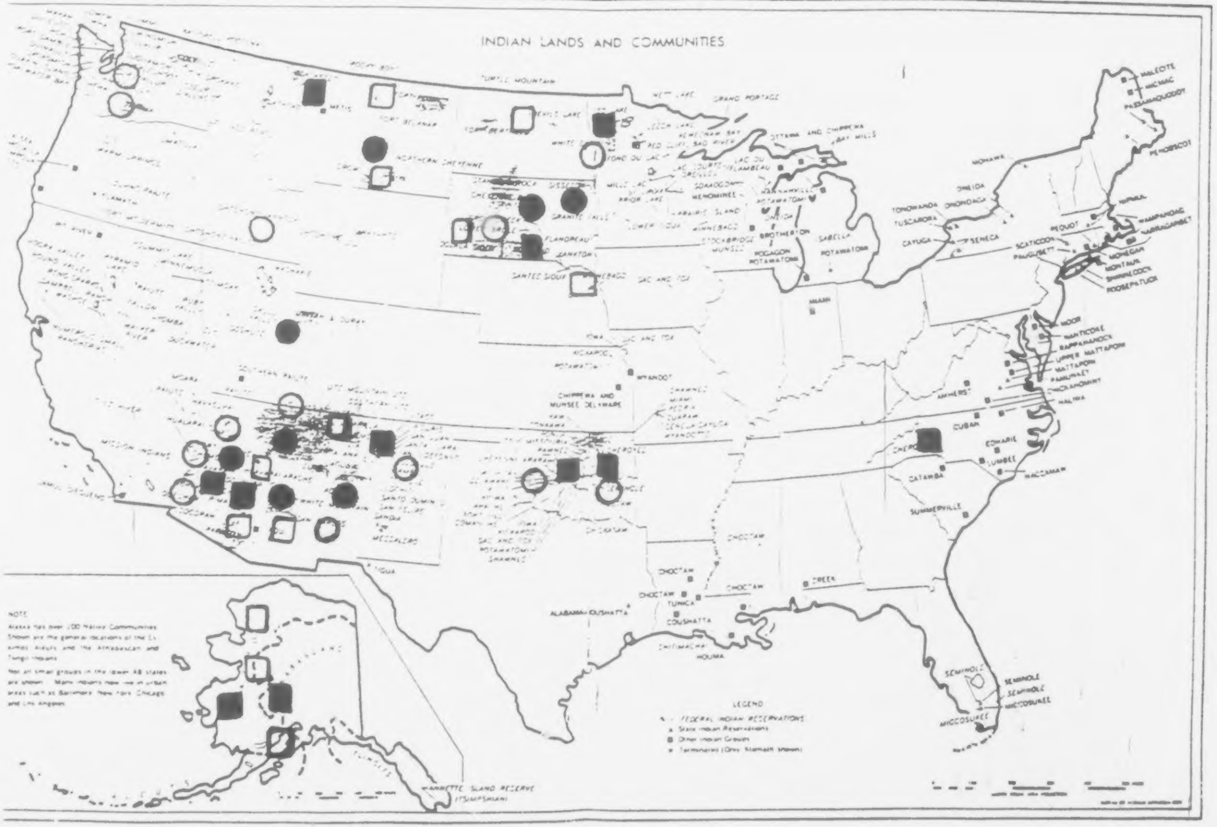
Frederick P. Baker
Frederick P. Baker
Health Systems Administrator

cc:
T. Batliner, DDS, Area Director, PAO
W. Bell, Ch., FMgr., PAO/EH&E

FPB:ajc

HOSPITALS AND CLINICS "COMPLETED"
BY IHS IN THE LAST [illegible] YEARS

● IHS clinics completed
○ IHS clinics "in progress"
■ IHS hospitals completed
□ IHS hospitals "in progress"


INDIAN LANDS AND COMMUNITIES
NOTE
Alaska has over 200 Native Communities. Shown are the general locations of the Eskimos, Aleuts and the Athabascan and Tlingit Indians.
Not all small groups in the lower 48 states are shown. Many Indians now live in urban areas such as Baltimore, New York, Chicago and Los Angeles.
LEGEND
FEDERAL INDIAN RESERVATIONS
State Indian Reservations
Other Indian Groups
Terminated (Only Klamath shown)

2/6/90

HOSPITALS, HEALTH CENTERS AND PERSONNEL QUARTERS CONSTRUCTED SINCE FY 1980

	Year Constructed	Total Appropriated
Hospitals:		
Bethel, AK	1980	$34,100,000
Ada, OK	1980	14,374,000
Cherokee, NC	1981	10,341,000
Red Lake, MN	1981	9,566,000
Chinle, AZ	1982	19,758,000
Tahlequah, OK	1983	21,334,000
Browning, MT	1985	15,086,000
Kanakanak, AK	1987	16,578,000
Crownpoint, NM	1987	17,734,000
Sacaton, AZ	1988	15,765,000
Rosebud, SD	1989	20,700,000
Subtotal		195,336,000
Health Centers:		
Cibecue, AZ	1980	750,000
Lodge Grass, MT	1982	1,485,000
Inscription House, AZ	1983	3,890,000
Ft. Duchesne, UT	1984	2,220,000
Tsaile, AZ	1984	3,856,000
Huerfano, NM	1984	3,304,000
Ft. Thompson, SD	1988	3,449,000
Kyle, SD	1989	3,209,000
Subtotal		22,163,000
Personnel Quarters:		
Red Lake, MN (39)	1980	2,400,000
Bethel, AK (40)	1980	4,467,000
Lodge Grass, MT (10)	1981	650,000
Chinle & Inscription House, AZ (Design)	1982	336,000
Inscription House, AZ (21)	1983	1,764,000
Chinle, AZ (161)	1983	12,236,000
Huerfano, NM (9)	1984	1/
Ft. Duchesne, UT (9)	1984	1/
Crownpoint, NM (36)	1985	3,352,000
Tsaile, AZ (23)	1985	2,141,000
Ft. Thompson, SD (13)	1986	1,279,000
Sacaton, AZ (8 Renovated)	1986	158,000
Kanakanak, AK (17)	1987	4,133,000 2/
Browning, MT (26)	1987	2,470,000
Subtotal		35,386,000
GRAND TOTAL		252,885,000

1/ Funds reprogrammed from Chinle and Inscription House personnel quarters projects.

2/ Funds appropriated to build 26 units but only 17 units can be built with the amount that was appropriated.

Nez Perce
TRIBAL EXECUTIVE COMMITTEE
P.O. BOX 305 • LAPWAI, IDAHO 83540 • (208) 843-2253

January 23, 1990

Terrence Batliner, D.D.S., Area Director
Portland Area Indian Health Service
1220 S.W. 3rd Avenue, Room 476
Portland, OR 97204

Dear Dr. Batliner:

The Nez Perce Tribe is very concerned about the continued inadequacy of the Lapwai Clinic facility. I understand that the Indian Health Service has scheduled major repairs for the Lapwai Clinic this spring to address facility deficiencies. While we welcome all efforts to prevent the deterioration of the Lapwai Clinic, we must point out that the building itself by IHS definition is totally "inadequate" for the purposes of providing ambulatory health care, and needs to be replaced.

The authorization from headquarters of the Indian Health Service to proceed on temporary construction and repair projects describes the Lapwai Clinic as in need of replacement (see attached memo). In fact, Mr. Bill Pearson, in his memo states. "...The present clinic has serious space deficiencies until the facility is replaced in the normal permanent construction cycle..." The formula for the national IHS Facilities Construction Priority System discriminates against communities like Lapwai, whose patient numbers do not compete with with other larger populations around the United States. Unless a strong case is made for smaller communities like Lapwai, it does not appear we will move up on the priority list for the replacement facility we desperately need. I am greatly concerned that the "temporary" repairs currently proposed not become permanent solutions to an unacceptable facility problem.

The Nez Perce Tribe does not feel that the proportionate support and resources are being provided for our communities. The inadequacy of the Lapwai Clinic is resulting in many people seeking out other forms of health care or in worse cases avoiding health care when needed. As more of our members stay away from the Clinic because of its overcrowding, inaccessibility and fire-safety code violations in the facility, the numbers of outpatient visits needed to justify a replacement facility begin to drop.

Based on a review of the documents on file, it appears that the Indian Health Service is minimizing the real facility deficiencies at the Lapwai site. The last "Deep Look" survey of the facility was done in 1987. The summary of findings indicates that the facility was looked at under the review category of "...Business Occupancy rather than the more restrictive Ambulatory Health Care category..." Would the findings of facility deficiencies been different had the facility been reviewed under the Ambulatory Health Care category as it should have been? The review by the Joint Commission for the Accreditation of Health Care Organizations found extensive facility deficiencies at the Lapwai site when they visited our facility last month. The Tribe believes the JCAHO facility deficiencies should be incorporated into the proposed repairs scheduled for this spring and that programmatic and facility deficiencies which are outside the realm of the planned repairs should be assessed and a proposal for priority facility replacement made to headquarters as soon as possible.

The Tribe would like to meet with you to discuss the needs for a replacement facility in Lapwai and to encourage your support to make a case for our unique situation to IHS headquarters. Please let me know when a meeting can be arranged.

Thank you.

Sincerely,

Allen V. Pinkham

Allen V. Pinkham
Chairman

cc: Frederick Baker, Health Services Administrator
Northern Idaho Indian Health Service Unit
Julia Davis, Health and Community Services Chairwoman, NPTEC

DEPARTMENT OF HEALTH & HUMAN SERVICES **Public Health Service**

PORTLAND AREA
INDIAN HEALTH SERVICE
FEDERAL BLDG. ROOM 476
1220 S.W. 3RD AVENUE
PORTLAND, OREGON 97204

FEB 9 1990

FEB 12 1990

Allen V. Pinkham, Chairman
Nez Perce Tribal Executive Committee
P.O. Box 305
Lapwai, Idaho 83540

Dear Chairman Pinkham:

Thank you for your letter of January 23 expressing concern over the status of the Lapwai IHS Health Center. As you know, the facility was built in 1970 to the then-prevailing standards and the building has been outgrown by the communities response to the services offered. The project underway this spring will allow us to correct Life-Safety Code and physical plant deficiencies and, to the maximum extent allowable within the constraints of the existing facility, address functionality issues. A new facility built to current IHS standards would be much larger than the existing Lapwai Health Center whose replacement is being proposed by the Portland Area in the area's Health Facility Master Plan.

I recognize your frustration concerning the seeming inability of IHS' Health Facilities Priority System to address the facility needs of smaller tribes. My staff has commented on certain aspects of this system in hopes of making it more even-handed toward the smaller tribes in the Portland Area but no final draft of this proposed methodology has been received from Mr. Pearson's office. Over a hundred ambulatory facilities are being sought by tribes throughout the nation and IHS Headquarters must identify and prioritize the most urgently needed facilities. In recent years, this system has allowed the Portland Area to replace facilities at Yakima, Fort Hall, and Puyallup. IHS' facility construction backlog exceeds $500 million with many proposed facilities such as Lapwai not yet included on the list. The administration's budget and congressional supplements allow IHS to meet only a fraction of this need annually.

I would be happy to discuss these concerns with you at your convenience. I am scheduled to be present at the Northern Idaho Service Unit Governing Board meeting on March 7. Please contact my secretary, Ms. Brittell (503/326-2020) to arrange a specific meeting time in conjunction with this trip.

Sincerely,

Peter Nakamura for

Terrence S. Batliner, D.D.S.
Director
Portland Area Indian Health Service

cc: Mr. Baker, Director, Northern Idaho Service Unit

DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Indian Health Service
Rockville MD 20857

MAR 9 1990

Ms. Jo Ann Kauffmann, M.P.H.
Evergreen Associates
206 G Street, N.E.
Washington, D.C. 20002

Jo Anne

Dear Ms. Kauffman:

I am responding to your letter of February 9 regarding the Inland Tribal Consortium (ITC) Regional Treatment Center project, and the existing Indian Health Service (IHS) clinic at Lapwai, Idaho.

First, you expressed concern about the apparent lack of communication between the Portland Area Office and the ITC regarding site acquisition, planning and design activities for the Regional Treatment Center, and suggested that a meeting of involved parties may be necessary to review project progress and reestablish a proposed schedule for project completion.

I agree that a follow-up meeting to the one held in May 1989 would be beneficial; however, there are some issues which need resolving before arranging such a meeting. Currently, the Office of the General Counsel (OGC) is reviewing language contained in the House of Representatives Committee on Appropriations Report 101-120, Department of the Interior and Related Agencies Appropriations Bill, 1990, to determine whether it provides authorization for the Indian Health Service to purchase a facility site using previously appropriated funds. The OGC is to provide us with its written opinion on this issue, as well as whether or not a separate resolution, supporting the selected site, is required from each involved tribe. Once we receive the OGC opinions, we will instruct Portland Area staff to schedule another meeting to discuss project progress, remaining items to be completed, and proposed completion dates.

Secondly, you related the Nez Perce Tribe's concern about the inadequacy of the existing IHS clinic at Lapwai, and urged consideration of the development of an alternate priority system for small facilities which presently have little chance of making the health facilities construction priority list.

Currently, the IHS is developing a leasing priority system for small health facilities constructed by tribes using non-IHS funding sources. Once developed, this system will enable the IHS to request congressional approval to lease up to 10,000 gross square feet (GSF) of space for which there is high relative need as determined by application of the priority system methodology.

Also, the Congress has directed the IHS to evaluate tribal proposals for constructing health facilities using non-IHS funding and submit a report by March 1990 on the feasibility of this approach. The IHS presently has no mechanism for supporting such projects (if greater than 10,000 GSF); however, if the Congress so directs, the IHS would develop an alternate priority system for rating projects of this nature. We expect to submit the report during March after which we will await further direction from the Congress.

When one or both of the above mentioned priority systems are developed, the Areas will be asked to submit applications for appropriate projects. The Nez Perce Tribe should continue to keep the Portland Area informed of its intentions in this regard.

I trust this information will be helpful.

Everett

Everett R. Rhoades, M.D.
Assistant Surgeon General
Director

Bill L. [illegible]
file N. Idaho Clin

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Memorandum

Date March 21, 1990

From Director, Division of Facilities Engineering
Portland Area Indian Health Service

Subject Trip Report, Spokane, Washington

To For The Record

On March 8, 1990, I attended a meeting to discuss options for providing alternative space for the Northern Idaho Service Unit. Persons in attendance included:

Allen Pinkham, Chairman, Nez Perce
Tom Perry, Health Director, Nez Perce
Terrence Batliner, Director, Portland Area Indian Health Service
Wesley M. Bell, Director, Division of Facilities Engineering

1. If all existing building deficiencies uncorrected:

Would not rate in top 30 or better on IHS new facility priority system. IHS experience is five years to replace a facility.

There has not been an indication of when there will be another application of the IHS new or replacement facility priority system.

Overview

Population generates workload.

Workload and facility factors generate facility score.

If raw score is within the top ten a Program Justification Document (PJD) is requested.

PJD justifies Program of Requirements (POR).

POR generates request for design estimate/construction estimate.

Phase I & II Site Survey initiated if in top 10 facilities on priority list.

Construction is in two phases:

Design funding and design-Phase I.

Construction funding and construction-Phase II.

2. A proposed lease priority methodology is scheduled to be implemented in FY 90 for FY 92.

3. Tribal initiatives outside IHS priority system are not supported by IHS or DHHS.

4. Best estimate of replacement facility size is 18-22,000 square ft.

5. Estimates

A. 22,000 square ft. building

97.73 ft.	2,150,060	
eqmt. mins.	61,525	
site mins.	94,160	
	2,305,745	
	1.07	Location
	2,467,147	
	1.10	Inflation
	2,713,861	
	.12	A & E & Construction Insp.
Design & Construction	$3,039,525	
or		
Design & Study Only	217,108	Design & Concept Study.

B. 28,000 square ft.

Design & Construction	$3,868,486
Design & Study Only	264,871

C. Staffing.

Estimated total staffing required is subject to full review of Tribal Specific Health Plans, and development of a Program Justification. For discussion if 18,000 OPV per year.

52 Full-Time Employees (FTE)

27 Existing FTE

25 Additional FTE Required @ $31,500 per FTE per year.

D. Equipment.

Cost for equipment is normally included in the construction budget for a new facility but if funded separately, as for a lease; cost for Group II equipment is estimated:

22,000 sq. ft. bldg. - $516,719

28,000 sq. ft. bldg. - $657,642

All costs and staffing projections are discussion estimates only. An assessment of the long-term goals and needs of the Northern Idaho Service Unit in combination with the development of a Program Justification Document is essential before any degree of reliability can be attributed to estimates presented.

Wesley M Bell

Wesley M. Bell

cc: Director, Office of Planning & Evaluation
SUD, Northern Idaho
Associate Director, Area Office Operations

JH0055

HOBBS, STRAUS, DEAN & WILDER
LAW OFFICES
1819 H STREET, N.W., SUITE 800
WASHINGTON, D.C. 20006
(202) 783-5100
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CAROL L. BARBERO (DC)
S. BOBO DEAN (DC, NY)
HAROLD M. GROSS (DC, CA, OR)
CHARLES A. HOBBS (DC)
FRANCES L. HORN (DC)
MATTHEW S. JAFFE (DC, MD)
MARSHA KOSTURA (DC, PA)
JOSEPH J. B. RYAN (DC, TX)
JUDITH A. SHAPIRO (DC)
CHRISTOPHER T. STEARNS (NJ)
JERRY C. STRAUS (DC)
DEAN B. SUAGEE (DC)
HANS WALKER, JR. (DC, ND)
LEROY W. WILDER (OR, DC, CA)

MICHAEL P. GROSS (NM, AZ)
KENNETH F. TWOROGER (DC, FL)
ROBERT H. WAGSTAFF (AK, KS)
OF COUNSEL

KAREN J. FUNK
GOVERNMENTAL AFFAIRS COORDINATOR
(NOT ADMITTED TO ANY BAR)

PORTLAND OFFICE:
0225 S.W. MONTGOMERY STREET, #6
PORTLAND, OREGON 97201
(503) 242-0708

NEW MEXICO AFFILIATE:
ROTH, VAN AMBERG, GROSS & ROGERS
P.O. BOX 1447
SANTA FE, NEW MEXICO 87501
(505) 988-8979 AND 983-7319

FLORIDA AFFILIATE:
TWOROGER & ASSOCIATES
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ANCHORAGE, ALASKA 99501
(907) 277-8611

April 11, 1990

The Honorable John McCain
United States Senate
111 Russell Senate Office Building
Washington, D.C. 20510

Attention: Mr. David McIntyre

Re: Indian Health Facility Needs

Dear Senator McCain:

We are writing on behalf on our clients, the Norton Sound Health Corporation and the Bristol Bay Health Corporation to submit certain information for inclusion in the record of the March 22nd hearing on the facility needs of the Indian health program. The Norton Sound Health Corporation (NSHC) and the Bristol Bay Health Corporation (BBAHC) are tribal organizations which provide health services to Native villages in Alaska and operate hospitals in Nome and Dillingham, respectively, under the Indian Self-Determination Act.

Our clients, while they have differing facilities needs, share in common the problem that their current facilities pose a threat to the health care of their clients. They also share in common the fact that under current Indian Health Service policies, there is no assistance in sight. There is no indication that, despite the serious facility problems, they will be placed on the IHS priority list for construction or renovation.

We hope that knowing some of the frustrating circumstances in which our clients find themselves with regard to facilities will be helpful in drafting legislation which will alleviate the circumstances of tribal health care providers in Alaska. Health care providers in Alaska are, of course, in extremely isolated regions with no opportunity to share facilities or services with other health care institutions. Unlike administrators of rural hospitals and clinics in the lower 48 states who are now combining or "downsizing" their facilities, the need in Alaska is for just the opposite. The population of Native people in Alaska is growing at a very high rate and there are no nearby non-IHS facilities with which to share services or facilities. According to the Bureau of the Census 1988 County and City Data Book, seven of the twenty five counties in the U.S. with the highest birthrates were in Alaska. Most all of the 25 counties are ones with high concentrations of Native people.

The general concerns of our clients are that the IHS priority systems for construction, renovation and repairs be "unfrozen", that leasing arrangements be facilitated and that adequate federal funding be made available for Indian health programs and facilities.

The **Norton Sound Health Corporation** provides hospital services funded by the Indian Health Service under the Indian Self-Determination Act in a structure dating from 1948. Structural deterioration in this building has resulted in serious code violations and health and safety deficiencies. Among the more glaring problems in our existing facility are: 1) settling of the foundation which will preclude any long term use of the facility; 2) considerable asbestos in both the new (1978) and old (1948) portions of the hospitals. Because of asbestos removal laws, remodeling is very difficult or nearly impossible; 3) no sprinkler system in the 1948 portion of the hospital which houses approximately one half of the health care programs; 4) poor wiring and plumbing, especially in the old portion of the hospital; and 5) serious deficiencies documented in a safety report for the kitchen, laundry, maintenance and boiler areas.

We enclose a copy of a schematic design prepared by Livingston, Sloane, Inc., which details immediate work to meet short-range program needs as well as a number of functional deficiencies. The schematic design is limited to Phase II construction (Phase I was a skilled nursing addition constructed in 1987/88.) and totals $13 million. This $13 million was a 1986 estimate and will need to be adjusted for inflation. Phase II construction would cover only half of the total construction project, and so a rough estimate for total construction costs (including about $3 million for administrative office space) is $40 million.

NSHC has attempted for several years to get the federal government to address this problem without success. In 1986 they were told that they could not be placed on the IHS priority system for construction because the IHS office of engineering services must first "stop in and look at the Norton Sound facilities." In addition, according to IHS at that time IHS policy is to concentrate "on government facilities and facilities leased by the government". We were told that no maintenance and repair funds could be allocated to meet NSHC needs because the facility is not federally-owned.

Subsequently, NSHC was informed that, indeed, since IHS funded hospital services in its facility it would be ranked on the IHS priority list, but a survey would have to be made first. Last year IHS finally made the inspection, and while a draft report has been provided to Norton Sound, no final report has emerged. Nor has Norton Sound been notified that its facilities needs have been prioritized. Now we have been informed that NSHC cannot be prioritized at this time because the IHS has "frozen" its priority system pending a review by the Senate Select Committee on Indian Affairs' of IHS construction priority policy.

NSHC is pleased that your Committee is looking at facility issues and seriously doubts whether you have, in fact, requested IHS to take no further action to address the health facility problems which plague its program until you have completed your review. NSHC urges that you consider steps to expedite the correction of health facility deficiencies in the Indian Health program.

The **Bristol Bay Area Health Corporation** operates the Kanakanak Hospital in Dillingham, Alaska. Although a new hospital facility was completed in 1986, there are three serious health and safety deficiencies which require correction.

The first problem is one of asbestos. Asbestos is present in 8,624 square feet of floor tile of the new facility and is also present in the old hospital facility which is now used for administration and in the old housing units. The cost of removing the asbestos in all these buildings is $5 million. An additional $198,352 is needed to replace the floor tiles in the hospital (at a cost of $23 per square foot).

The second major problem is the insufficient load capacity of the roof of the new hospital. Concern has increased with the collapse of a school roof in Dillingham and the collapse of other roofs in southwestern Alaska. BBAHC has now obtained information from the IHS and the Office of Engineering Services which confirms their concern about the ability of the hospital roof to withstand the snows received in Dillingham. Attached is March 28th correspondence from the IHS which says that recent criteria developed by the University of Alaska regarding designs for snow accumulation show the hospital roof to be insufficient. The roof on the new facility is designed to withstand only 30 pounds per square feet, and BBAHC believes serious consideration should be given to construction of a pitched roof which will withstand 78 pounds per square feet. The cost of renovation of the roof is estimated to be $1.6 million.

In addition, BBAHC's old hospital facility also has problems with electrical wiring and plumbing These health and safety deficiencies are urgent and are simply not being addressed in an expeditious manner by IHS' present approach to construction and renovation of health facilities.

The final major problem is, as with asbestos, an environmental issue. The Kanakanak Hospital compound is experiencing an oil seepage problem. The seepage is under the new hospital and in six housing units for medical personnel (duplex numbers 316, 317 and 318). This is an urgent matter and a complicated one to solve. It could involve lowering the water table, sealing off the basements, moving the houses, or in some other way isolating the oil. The BBAHC is working with the Area IHS Contracting Office to ensure that the problem is fully identified and corrected and that the IHS retains liability for the associated costs. We are not at this point satisfied with the progress being made by IHS and are concerned over whether they will aggressively seek funding to rectify this most serious problem of oil seepage. The Alaska Department of Environmental Conservation (DEC) has expressed great concern over the oil seepage, particularly with regard to the salmon-rich Nushagak River where oil has seeped over the river banks into local subsistence nets and into the fish going up river to spawn. The DEC has the ability to levy large fines and take other legal action if the problem is not addressed in a timely fashion.

We know that other tribal and IHS facilities have environmental problems. While these problems may not be ones of oil seepage but more likely ones of PCBs and other hazardous wastes generated from hospitals, we believe that IHS liability for environmental problems at IHS-funded facilities is a legitimate consideration in drafting health facility legislation.

We are dismayed that IHS appears more concerned about maintaining the procedural aspects of its priority system than it is about addressing severe health and safety deficiencies in the facilities serving Indian and Alaska Native people. We urge that your Committee take action to break this logjam. One step which should be taken is to increase the annual appropriations for new construction and for repair and maintenance of facilities. The failure of the budget requests to include sufficient funding to address the ever-mounting backlog of unsafe facilities is, of course, a major contributor to the problems faced by our clients.

However, we also recommend that new and innovative approaches be encouraged so that some of these problems can be addressed without depending on construction and renovation appropriations. In particular, we urge that the authority to lease provided in the 1988 Amendments to the Indian Health Care Improvement Act be used to address this problem. The FY1990 Interior and Related Agencies Appropriations Act, P.L. 101-121, precludes IHS from entering into an initial leasing arrangement with a tribe or tribal organization of a facility without advance provision in an appropriations act. This is just another "catch 22" for tribes trying to assure that the facilities in which their members receive health care are safe. The Appropriations Act is also inconsistent with Section 704 of the Indian Health Care Improvement Act which provides that such leases are authorized "notwithstanding any other provision of law" but IHS has recently told us that it is under a legal requirement to lease only when the facility has been placed on the priority system with approval of the appropriation committees.

If leasing arrangements between IHS and tribes and tribal organizations can be utilized to eliminate the backlog of deficient health facilities, it will obviously assist not only the tribes capable of utilizing such arrangements, but other tribes as well, since the construction funding can then be focused on those tribes. We request that legislation drafted as the result of the comments received for the Indian health facilities hearing include provisions which will facilitate leasing arrangements when the tribal contractor can put together a credit package for the needed construction, renovation or repair. Obviously, the easing of leasing arrangements will also make it easier to obtain credit.

We urge that this problem be given serious study and that your Committee work closely with IHS to assure that the present freeze be cancelled, that the Norton Sound Health Corporation and the Bristol Bay Area Health Corporation's facility needs be promptly prioritized and that leasing arrangements or other new approaches be utilized to eliminate the existing scandalous situation in which the federal government provides health care for Indians and Alaska Natives in facilities which are themselves a threat to the health of the patients.

Sincerely,

HOBBS, STRAUS, DEAN & WILDER

By: S. Bobo Dean

cc: Ms. Carolyn Michels
Mr. Robert Clark
Honorable Ted Stevens
Honorable Frank Murkowski
Honorable Don Young
Honorable Daniel Inouye

FEDERAL EMPLOYEE OCCUPATIONAL HEALTH PROGRAM
REGION X

Asbestos Survey Report On

NATIVE HEALTH SERVICE HOSPITAL
REF. 89-CR-10-0125
DILLINGHAM, ALASKA
SEPTEMBER, 1989

U.S. PUBLIC HEALTH SERVICE

Table 3	A list of all materials that contain 1% or more asbestos with the percent of asbestos in the material and a description of the material.
Table 4	A list of all materials that contain zero or less than 1% asbestos and a description of the material.
Table 5	A list of the location identification numbers (or codes) and the corresponding buildings, floors and rooms. These locations are also shown on the floor plan drawings found in Appendix 1.
Table 6	A summary of the bulk asbestos samples collected and the analytical results.
Table 7	A list of abbreviations used for the various types of materials tested.
Table 8	A list of the abbreviations used to describe the floor, room, and use of the room.
Table 9	A list of the explanations for the abbreviations used in Tables 1 and 2 for response action, condition of the material and potential contact and disturbance of the asbestos-containing materials.

Kanakanak Native Health Service Facilities

Building 301: Old Hospital (Administration)

High Concern: There is deteriorated asbestos-containing wall joint compound in the stairwell of HP002. The loose material should be cleaned up and the unstable material in the stairwell walls should be removed as soon as feasible.

Medium Concern: None

Low Concern: There is a considerable quantity of asbestos-containing flooring material present throughout the old hospital (now administrative offices), with approximately 5,120 square feet of floor tile and about 8 square feet of floor sheet. This asbestos-containing material is in good condition, and can be left in place, if maintained in good condition.

The sample results show many areas have asbestos-containing joint compound used on the finished interior walls.

Until more comprehensive sampling can be done to isolate rooms with positive wall materials from rooms that do not, it is assumed that all the rooms are affected with this asbestos-containing material. In the basement and two floors of the old hospital, approximately 16,253 square feet of asbestos-containing wall surface material (joint compound) is present. The concentration of asbestos is low and well contained beneath the painted surfaces and in the adhesives of the compound itself. This material can be left in place and maintained in good condition, then removed when walls have to be removed or changed.

Building 303: Staff Quarters

High Concern: Approximately ten linear feet of asbestos flue insulation is present in the boiler room of this building. Because this material is in an unstable condition and highly friable, it should be removed as soon as feasible.

Medium Concern: Sixteen asbestos pipe joints and elbows were found in selected rooms of the basement. This material is in good, stable condition and does not pose a health risk at this time. However, these joints should be removed when the flue insulation is removed, or as soon as feasible.

Low Concern: There is about 318 square feet of floor sheet and 21 square feet of floor tile in a number of rooms in the staff quarters. This material can be left in place and maintained in good condition, however, it should be removed during renovation work.

Also, there is approximately 3,210 square feet of asbestos-containing wall surface material (joint compound) throughout the building. This asbestos-containing material is in good stable condition and does not present a health hazard unless crushed, broken, or penetrated. The concentration of asbestos is low and well contained beneath the painted surfaces and in the adhesives of the compound itself. This material can be left in place and maintained in good condition, then removed when walls have to be removed or changed.

Buildings 304: Staff Quarters

High Concern: None

Medium Concern: There is approximately 90 linear feet of asbestos pipe insulation and 26 asbestos pipe joints and elbows throughout the basement as well as 62 square feet of asbestos tank insulation in the boiler room. This asbestos-containing material is in fairly good, stable condition and does not pose a health risk at this time. This material should be maintained in good condition and removed when other asbestos-containing material is scheduled for removal or as soon as feasible.

Low Concern: There is about 1,570 square feet of floor tile and 64 square feet of floor sheet in a number of rooms in the staff quarters. This material can be left in place and maintained in good condition, however it should be removed during renovation work. Also, there is approximately 6,039 square feet of asbestos-containing wall surface area throughout the building. This asbestos-containing material is in good stable condition and does not present a health hazard unless crushed, broken, or penetrated. The concentration of asbestos is low and well contained beneath the painted surfaces and in the adhesives of the compound itself. This material can be left in place and maintained in good condition, then removed when walls have to be removed or changed.

Building 305: Old Generator Building

No asbestos-containing materials were identified.

Building 307: Staff Quarters

High Concern: Approximately ten linear feet of asbestos flue insulation is present in the boiler room and four linear feet of asbestos pipe insulation in the entry way, RE704, of one residence. Because this material is in an unstable condition and highly friable, and as the pipe insulation is easily accessible, too, these asbestos-containing materials should be removed as soon as feasible.

Medium Concern: None

Low Concern: There is about 530 square feet of floor tile in one residence of the building. This material can be left in place and maintained in good condition, however, it should be removed during renovation work.

Building 308: Storage

High Concern: Approximately ten linear feet of asbestos flue insulation is present in the boiler room of this building. Because this material is in an unstable condition and highly friable, it should be removed as soon as feasible.

Medium Concern: None

Low Concern: There is about 530 square feet of floor tile throughout the rest of the quonset hut. This material can be left in place and maintained in good condition, however it should be removed during renovation work.

Building 309: Storage

No asbestos-containing materials were identified.

Building 310: Dental Unit

High Concern: None

Medium Concern: None

Low Concern: There is about 200 square feet of floor sheet and 160 square feet of floor tile in the operatories of this building. This material can be left in place and maintained in good condition, however it should be removed during renovation work.

Building 311: Storage

No asbestos-containing materials were identified.

Building 312: Water Treatment Plant

No asbestos-containing materials were identified.

Building 313: Storage

No asbestos-containing materials were identified.

Building 315: Staff Quarters

High Concern: None

Medium Concern: There is approximately 75 square feet of asbestos tank insulation in the boiler room. This asbestos-containing material is in fairly good, stable condition and does not pose a health risk at this time.
This material should be removed when other asbestos-containing material is scheduled for removal, or as soon as feasible.

Low Concern: There is about 1,545 square feet of floor tile in a number of rooms in the staff quarters. This material can be left in place and maintained in good condition, however it should be removed during renovation work. Also, there is approximately 4,320 square feet of asbestos-containing wall surface area throughout the building. This asbestos-containing material is in good, stable condition and does not present a health hazard unless crushed, broken, or penetrated. The concentration of asbestos is low and well contained beneath the painted surfaces and in the adhesives of the compound itself. This material can be left in place and maintained in good condition, then removed when walls have to be removed or changed.

Building 316: Staff Quarters

High Concern: None

Medium Concern: There are approximately 270 asbestos pipe joints and elbows throughout the basement. This material is in good, stable condition and does not pose a health risk at this time. However, these joints should be maintained in good condition and be removed when other asbestos-containing material is scheduled for removal or as soon as feasible.

Low Concern: There is about 1,565 square feet of floor tile in a number of rooms in the staff quarters. This material can be left in place and maintained in good condition, however it should be removed during renovation work. Also, there is approximately 3,798 square feet of asbestos-containing wall surface material (joint compound) throughout the building. This asbestos-containing material is in good, stable condition and does not present a health hazard unless crushed, broken or penetrated. The concentration of asbestos is low and well contained beneath the painted surfaces and in the adhesives of the compound itself. This material can be left in place and maintained in good condition, then removed when walls have to be removed or changed.

Building 317: Staff Quarters

High Concern: None

Medium Concern: There are approximately 237 asbestos pipe joints and elbows throughout the basement. This material is in good, stable condition and does not pose a health risk at this time. However, these joints should be maintained in good condition and be removed when other asbestos-containing material is scheduled for removal or as soon as feasible.

Low Concern: There is about 1,862 square feet of floor tile in a number of rooms in the staff quarters. This material can be left in place and maintained in good condition, however it should be removed during renovation work. Also, there is approximately 3,774 square feet of asbestos-containing wall surface area throughout the building. This asbestos-containing material is in good, stable condition and does not present a health hazard unless crushed, broken, or penetrated. The concentration of asbestos is low and well contained beneath the painted surfaces and in the adhesives of the compound itself. This material can be left in place and maintained in good condition, then removed when walls have to be removed or changed.

Building 318: Staff Quarters

High Concern:	None
Medium Concern:	There are approximately 240 asbestos pipe joints and elbows throughout the basement. This material is in good, stable condition and does not pose a health risk at this time. However, these joints should be maintained in good condition and be removed when other asbestos-containing material is scheduled for removal or as soon as feasible.
Low Concern:	There is about 1,412 square feet of floor tile in a number of rooms in the staff quarters. This material can be left in place and maintained in good condition, however it should be removed during renovation work. Also, there is approximately 3,512 square feet of asbestos-containing wall surface area throughout the building. This asbestos-containing material is in good, stable condition and does not present a health hazard unless crushed, broken, or penetrated. The concentration of asbestos is low and well contained beneath the painted surfaces and in the adhesives of the compound itself. This material can be left in place and maintained in good condition, then removed when walls have to be removed or changed.

Building 319: Sewage Treatment Plant

No asbestos-containing materials were identified.

Building 401: New Hospital

High Concern: None

Medium Concern: None

Low Concern: There is approximately 8,624 square feet of floor tile in various rooms throughout the hospital. This material can be left in place and maintained in good condition, however it should be removed during renovation work.

Building 402: Garage/Incinerator/Generator Shop

No asbestos-containing materials were identified.

Trailer #2: Staff Quarters

No asbestos-containing materials were identified.

Trailer #3: Staff Quarters

No asbestos-containing materials were identified.

Trailer #4: Staff Quarters

High Concern: None

Medium Concern: In all rooms except the bathrooms of Trailer #4, an asbestos-containing acoustical material has been applied to the ceilings. Known as a "popcorn" ceiling texture, the composition of this material has between 10% and 40% chrysotile asbestos. This asbestos-containing material is in fairly stable condition and should not present a health hazard to occupants unless the latex encapsulant is penetrated or abraded resulting in the release of airborne fibers. There are stains on the ceiling indicating the intrusion of water into this asbestos-containing material resulting in eventual delamination from the substrate and subsequent fiber release. Therefore, to prevent further water damage from destabilizing this asbestos-containing material, this material should be removed as soon as feasible.

Low Concern: There is about 140 square feet of floor sheet laid in the entry ways of the residence. This material can be left in place and maintained in good condition, however it should be removed during renovation work.

There is a moisture barrier applied to the exterior skirting composed of a tar-based asbestos impregnated felt paper.

This material can be left in place and maintained in good condition, however this asbestos-containing material should be removed when other asbestos-containing material is scheduled for removal or during remodel time.

Trailer #5: Community Health Clinic

No asbestos-containing materials were identified.

VII. RECOMMENDATIONS

A. Remove thermal insulation around boiler exhaust flues in RE703, RE181, SR006 and reinsulate (if necessary) with asbestos-free material. Removal shall be by appropriately trained personnel and shall perform the removal so as to minimize potential exposures by proper removal techniques.

B. Maintain all asbestos-containing thermal, flooring, and roofing materials in good condition. Consider removal during remodel work, if and when any asbestos-containing material becomes deteriorated, or when other asbestos-containing material is removed from the buildings.

C. Label the contents of all thermal insulation material (pipes, tanks, flues, etc.) either "contains asbestos" if it has 1% or more asbestos or "no asbestos" or shall be done with care in an expert manner. Repair or replacement required because of damage by contractor's forces shall be at the contractor's expense.

15. PAYMENT FOR MATERIAL AT LOCATIONS OTHER THAN THE SITE

FAR 52.232-5, "Payment Under Fixed-Price Construction Contracts," is supplemented as follows.

a. In general, construction work will be compensated upon installation in the project. The Contracting Officer will consider special cases for compensation to the general contractor for equipment and materials stored in Seattle. The general contractor shall arrange verification by the Contracting Officer of the presence of the subject items in a bonded warehouse, and shall provide insurance thoroughly suitable to cover shipment from that warehouse to the job site. The Contracting Officer shall be named, at his or her discretion, as co-holder with the general contractor of all bonds and insurance for this process, which shall in no way relieve the general contractor and/or his assignees and the several bonders and insurers of responsibility for completing the project.

16. ASBESTOS PROHIBITED

Materials or equipment containing asbestos shall not be used in this project. It is the responsibility of the contractor to assure compliance with this prohibition. Approvals of samples and shop drawings by the Government and/or the A/E shall not relieve the contractor of this responsibility.

17. OFFICE SPACE FOR ARCHITECT-ENGINEER AND GOVERNMENT PERSONNEL

a. The contractor shall provide office space for the A/E and Government personnel with furnishings and equipment. Minimum provisions shall be as follows:

(1) 240 SF floor space, nominal 12' x 20' x 7'-6" ceiling height. Insulated and finished inside with plywood, with at least one 3'-6" x 2'-6" operable double glazed window.

(2) One 60" x 30" stock desk with drawers and with a desk chair. Two layout tables, minimum 6' x 3' each with draftsman stool.

(3) One telephone on independent line.

(4) Heated to maintain 70^{o}F.

(5) With electrical light fixtures providing minimum 50 fc.

SENT BY: KANAKANAK HOSPITAL 04-03-90 07:33AM 9078429354→ 12022966834 # 1

DEPARTMENT OF HEALTH & HUMAN SERVICES
PUBLIC HEALTH SERVICE
Alaska Area Native Health Service
P. O. Box 107741
Anchorage, AK 99510-7741

March 28, 1990

Our Reference: A-HFS

Mr. Robert Clark
Executive Director
Bristol Bay Area Health Corporation
P. O. Box 130
Dillingham, AK 99576

Dear Robert:

Subject: Kanakanak Hospital Snow Load

Your letter of March 16, 1990, brings to our attention your concerns about the snow loading on the hospital roof. We have also had concerns, and our Health Facilities staff began looking into this potential problem when unusually heavy snows were experienced in the Dillingham area last year.

Informal inquiries by our staff with the hospital structural designer revealed that the roof may not be designed to handle unusually large snow accumulations. We requested that a more formalized evaluation be conducted through the Office of Engineering Services (OES). This has just recently been completed, and a memorandum giving the results of the OES evaluation was recently sent to Mr. John DeLapp, along with a copy to your Facility Manager, Mr. Garth Geiglein. The OES analysis indicates that steel supporting roof beams were designed to accommodate a "live load" of 38 pounds per square foot.

This design loading met the code criteria when the building was designed, however, more recent criteria developed by the University of Alaska indicates that higher snow loadings should be used for Dillingham. Certainly, the last two winters would confirm this. Therefore, we are proceeding with an in-depth evaluation of the problem and possible ways to correct this deficiency.

In the meantime, removing snow from the roof must be done when the accumulation approaches the design limit. I understand that Mr. DeLapp and Mr. Geiglein have already agreed on this approach and that snow removal has already taken place earlier this winter. Please contact Mr. DeLapp if you have any other concerns at this time.

Sincerely,

G. H. Ivey
Director
Alaska Area Native Health Service

cc: John DeLapp, A-HFS
Mike Rowe, A-RHDU

BRISTOL BAY AREA HEALTH CORPORATION
P.O. BOX 130 • DILLINGHAM, ALASKA 99576
(907) 842-5201 or (907) 842-5202

MAR 1990

March 16, 1990

Gerald Ivey, Director
AANHS
250 Gamble Street
P.O. Box 107741
Anchorage, Alaska 99501

Dear Gerry:

I'm writing about a real and potentially very serious concern. Our concern is whether or not the flat roof designed only for 30 lbs. per sq. ft. on our hospital is safe enough structurally to withstand the level of snow load we are experiencing. This is separate from our original concern over a flat roof versus a pitched or sloping roof is being more practical, and cheaper in operation and maintenance costs etc. when first discussing our new hospital.

Timing is critical if funding is needed to resolve our "life safety" concern. The answer to our question will hopefully not be too late to help Kotzebue and ANMC in their planning efforts if as we suspect our roof is not designed to withstand the snow load (see attached) as should be. Already congress has had their hearings on the budget as you receive this letter. Deadlines for Administrative budgets leave it to the political or supplemental request process. The State legislature if they were able to help is half way through their process.

Since September when we put in our original request to Area on the load bearing question we have only received two responses (see attached September 20, 1989 and December 8, 1989) to our request for clarification to our concern. This is a definite JCAHO concern too. Things seem to be bogged down at The Office of Engineering Services (OES). Perhaps you can stress to Jim Ishihara or our good friend Ken Harper or their boss' that if we do not hear from them by the end of this month we will ask for a congressional inquiry. The reason, again is time for supplementals through the system - BBAHC to Area to Headquarters to Congress or by BBAHC directly to Congress is now, with the appropriate justification.

Besides the Aleknagik school roof collapsing, the Dillingham School has had a problem with a structural beam in their school partially collapsing forcing the school to close for a week while reconstruction work took place, and a couple of days ago a boat warehouse collapsed on a boat and some vehicles. The state, city and personal budgets of people have all been exceeded due to this years heavy snow fall. The flat or poorly pitched - roofs are taking the worse beating. We customarily build structures with appropriately pitched roofs as that is what we feel is the standard for arctic climate. We are more convinced than ever that this route is the most cost effective way to go over the life of a building. One way or the other the government must pay for poor construction or design defects that often could have been very simply by passed. Lets hope we learn from their costly lessons.

God forbid, our hospital roof collapses because it was not properly designed. Worse yet someone gets hurt.

Gerry, I really don't know the answer. I've been told the normal life span or warrantee on a flat roof is some 10 years with minor maintenance and repair. Historically, a flat roof would need to be replaced every 10-12 years. We are approaching the half way mark with some otherwise miner problems of leaking. The cost to shovel off snow in critical to prevent undue stress. I'm sure it doesn't help the life span of the roofing material, but that is the trade off. Also, it doesn't help our limited M&R budget necessary for numerous other projects.

We would like strong consideration to be given to seeking on appropriate roof (78 lbs. per square foot)to with stand the snow, rain and winds prevalent in our region. We suggest a metal sloping or pitched style roof as our preference to their ease of maintenance and cost effective over the life of the building. This could be a real challenge since we have several appendages on the roof (sky lites, etc.) but we have always been in favor of function over aesthetics.

Thank you for whatever you can do to expedite or answer to our concern. I see in the Anchorage papers that all over the south central area buildings are collapsing. That sure doesn't make us feel any better. We have our next scheduled Executive Committee (Board) meeting on 3/28-30/90 in Dillingham. Mike Rowe from your office will be out for a visit. Perhaps he might be able to bring any new information you have received to us then.

Sincerely,

Robert J. Clark
Executive Director

cc: Jay Toth
Garth Geiglein
Bob Wagstaff
S. Bobo Dean

UNITED STATES GOVERNMENT

memorandum

DATE: December 8, 1989

REPLY TO ATTN OF: Chief, Area Health Facilities Section
Alaska Area Native Health Service

Refer to: A-HFS

SUBJECT: Kanakanak Hospital Snow Loading

TO: Jim Ishihara, P.E.
Office of Engineering Services, Region X

This is to request assistance from your office in determining what the acceptable snow loading is for the Kanakanak Hospital.

As I explained in our recent conversation, the roof of a new school in a nearby village (Aleknagik) collapsed last winter from heavy snow. We were told that the school roof was designed for 35 psf. This caused us to examine what snow loadings we can expect in Dillingham and what loading the hospital roof can withstand.

After inquiring, we received the attached letter from the structural engineer which indicates that the hospital roof was designed for a loading of about 30 psf. However, a recent reference by the University of Alaska indicates that a 50 year return interval ground snow loading in Dillingham would be 111 psf. I left our copy of this reference with Jim Thode so your office could make a copy.

In view of this, we would like the structural engineer to take a closer look at what loading the hospital roof can withstand. We would like to know what strengthening, if any, is needed to insure local snow loads can be met.

Until we have more definite information, we will assume that when snow depths and densities combine to produce a loading of 30 psf, we will begin removing snow from the roof.

Please coordinate your activities on this matter with Chuck Bailey in our office (271-4782). Thank you for your assistance.

John R. DeLapp

John R. DeLapp, P.E.

Attachment

cc: Chuck Bailey
Jeff Smith

OPTIONAL FORM NO. 10
(REV. 1-80)
GSA FPMR (41 CFR) 101-11.6
5010-114

[illegible]
CONSULTING ENGINEERS
SPOKANE OFFICE: E. 1819 SPRINGFIELD • SPOKANE, WA 99202 • (509) 535-0136

September 20, 1989

Mr. Charles Bailey
Environmental Health - Engineer Branch No. 65
22 W. 8th Avenue
Anchorage, Alaska 99513

Re: Bristol Bay Comprehensive Health Care Facility
Kanakanak, Dillingham, Alaska

Dear Mr. Bailey:

This is in response to a telephone call I received from Carroll Martell requesting that the design snow load for the subject project be sent to you.

The basic design snow load is 30 lbs. per sq. ft. (PSF). Also, additional snow load is applied where drifting occurs around the clerestory, and adjacent to the original wood framed hospital building. Around the clerestory, the maximum design snow load is 112 lbs. per sq. ft. (PSF). The drifting loads were determined using the procedure described in the Uniform Building Code (UBC).

Should there be any questions, please call.

Very truly yours,

ATWOOD-HINZMAN

Charles W. Hinzman

Charles W. Hinzman, P.E.

CWH:jg

Bristol BayTimes
&
Dutch Harbor Fisherman

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Vol.10 No. 11 "Spawned Weekly In Southwest Alaska" March 16, 1990

Coast Guard not committed to Egegik patrol

by David McElroy
Staff Writer

NAKNEK — Borough officials have appealed to the U.S. Coast Guard to patrol the Johnson Hill and Egegik lines during the salmon season, but Coast Guard officials say that's the state 's responsibility.

Capt. Karl Luck, Coast Guard Chief of Operations for Alaska in Juneau, said "the state has to accept some responsibility for the way it manages fisheries in state waters."

Borough Manager Lanston Chinn said Monday that Police Chief Floyd Steele planned to plead the borough's case in Juneau this week, asking for a Coast Guard presence after receiving numerous complaints about aggressive fishermen ramming boats.

Chinn said local fishermen had indicated they would prefer to pay the price of increased Coast Guard presence if it would reduce the incidence of boat collisions and rammings.

"There is a lot of bumping and crowding," Luck acknowledged. "It's a chaotic way to run an operation. But if that is what the state has regulated, the state should correct the situation."

Luck said the Coast Guard was studying Bristol Bay

See COAST GUARD Page 3

Snow collapses roof; ice fall injures man — Heavy snow collapsed the roof of a boat storage barn on Windmill Hill Monday night, damaging a pickup truck, a boat and other equipment inside. In a separate incident, Ian Alexander of Dillingham suffered a broken leg when snow and ice avalanched off his roof Tuesday. Anderson was flown to Anchorage where he was reported in satisfactory condition Wednesday.

Children pay the price for mother's drinking

FAIRBANKS (AP) — The first time Betty saw her adopted daughter's spindly legs, widely spaced eyes, hairy face and flat, shrunken head, her heart paused.

Betty knew the baby was born to a chronic alcoholic when she adopted her. She knew booze had saturated the infant's body as she developed inside the womb. And she knew the liquor the child's mother drank while pregnant left the baby with Fetal Alcohol Syndrome.

"She reminded me a lot of a spider monkey," Betty said.

When Betty and her husband adopted the child in Fairbanks 10 years ago, however, they did not know their daughter's chance for a normal life was irretrievably gone.

"I was all fired up about what we could do," Betty said. Now working for Tanana Chiefs Conference, Betty previously was Fetal Alcohol Syndrome educator for Fairbanks Native Association.

Though small for her age, the girl, now 12, has outgrown most of the obvious physical characteristics typical of infants born with the syndrome—thick hair covering the face, a narrow, flat head, a thin upper lip, slanted eyes set wide apart.

The invisible damage to her brain remains.

At least 29 children are born in Alaska each year with Fetal Alcohol Syndrome, according to state figures. Health officials estimate as many as 15 times as many are born suffering from the less obvious Fetal Alcohol Effects.

The lifetime cost for medical and supervisory care for one child with the full syndrome is conservatively estimated at more than $1.4 million, according to a 1989 state Senate study. Few parents can afford the costs of caring for a FAS child, so the state ends up footing the bill, the study found.

Because improved medical technology is keeping alive FAS babies who would have died 10 years ago, the burden on the state is increasing, the study said.

A growing awareness of the problem has prompted Tanana Chiefs Conference, the Interior's non-profit Native social services organization, to make Fetal Alcohol Syndrome prevention one of its top priorities for 1990. It has also led to the recent formation of a Fetal Alcohol Syndrome support group in Fairbanks for parents and caretakers of FAS children.

The focus also has turned to Juneau and the state Legislature. Bethel Republican Sen. Johne Binkley, who represents interior Alaska and half the Yukon-Kuskokwim Delta, introduced a packet of bills this session designed to stop women from drinking while pregnant.

"I think that the public is becoming more and more aware of FAS, but even now I'm hearing stories about people's doctors who say it's OK to have a drink to relax while you're pregnant," Binkley said.

"We need to do anything we can do to raise public awareness."

One bill would allow the state to commit, without her consent, an alcoholic,

Tax help just a phone call away

If you are stuck on a particular federal tax problem or just want general tax information, the Internal Revenue Service has several ways to help you by phone.

First, there is Tele-Tax. This is a recorded toll-free message service on about 140 specific tax information topics. Look through the list of Tele-Tax subjects in your tax package to find the tax topic you need.

If more specific information is needed, IRS telephone assistors staff their phones during normal business hours.

Persons living outside of the Anchorage area can call toll-free, 1-800-424-1040

Maintenance workers remove snow from a sagging portion of the Dillingham High School roof

Roof OK, inspectors say; gymnasium re-opened

DILLINGHAM — Partial collapse of a section of the high school roof led officials to close one wing of the building for most of the week. But by week's end only the girls' locker room was still off limits.

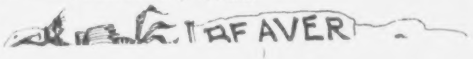
Although the snow-load was only a fraction of last year's, a laminated wood beam supporting a portion of roof over the locker rooms split and sagged last weekend, damaging ceilings in the locker rooms and hallway adjacent to the gym.

"We were deeply concerned," Principal Larry Price said Wednesday. "We reacted in a way that perhaps was over-kill, but it was better to be safe."

School officials initially closed the gym, music room and other adjoining rooms, but by Wednesday it was clear only the locker room area was damaged, and the gym and other rooms were reopened.

According to Price, a small post which supported the beam at its midpoint apparently slipped out of place. The post may have slipped when the beam sprang back after the pressure of last winter's unusually heavy snow load was released, Price said.

Nearby roof beams have been checked, and are undamaged, Price said. An insurance inspector and a local contractor declared the neighboring gym and other rooms safe for use Wednesday, after snow was removed and the damaged roof had been shored up. An engineer was to inspect the damage later in the week as well, Price said.



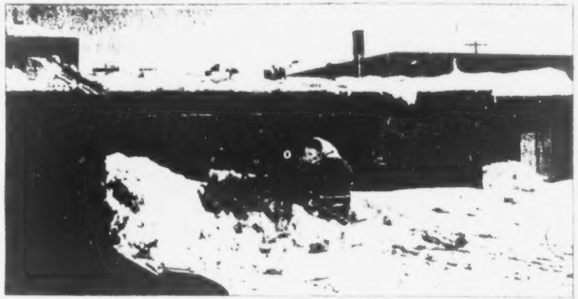
encourage them to find out how vocational education teaches young people the skills they'll need to be productive workers - and to be community leaders."

Elison explained that participation in vocational programs supplements the practical, technical training students receive in school by giving them practice at decision-making, organizing, and cooperating to meet a goal.

The importance of vocational education cannot be

(See Voc. Ed. Activities, in Center)

Pictured Left to Right: Mary Barnes, Tom Woods and Gwen Gustafson were recognized by their teachers as this school year's outstanding Vocational Education students.



Snow Damages School Roof

Heavy snow damaged a portion of the High School's roof last week. School officials were notified Monday that a support brace had slid and fractured a laminated beam, seriously compromising the roof above the entire area between the school's shop and gym.

"The gym is okay," said Principal Larry Price, "but the adjacent areas are damaged."

"My main concern right now is the safety and health of the students," added Price.

The girls' and boys' locker rooms, the shower rooms, and the weight and training areas are off-limits to students and teachers until engineers and inspectors certify that the damage has been repaired.

Protective gates seal off the corridors, and locked doors and signs are also being utilized to ensure that unsuspecting students don't wander into potentially dangerous areas.

Snow removal is currently being conducted on the roof. It is believed that the structural damage may be cumulative; the roof may have been weakened last

(See Roof Damage on Page 12)

McGill Targets Permit Transfers

by Kathyleen Tully

Referring to Joe McGill, Mayor of Dillingham, as "father of the limited entry system," House Representative George Jacko cited McGill for his success as chairman of the House Resource Committee in passing legislation aimed at promoting conservation and regulating participation in the fishing industry with the welfare of the public in mind.

McGill recently participated in a teleconference with Jacko, individuals from the Yukon-Kuskokwim fisheries, members of the House Resource Committee, and others concerned with limited entry issues.

House Bill 285, a bill dealing with "...qualifications for transferees...limited entry permits," is before the legislature this session. It is intended to keep permits in the hands of local fishermen, and to lower the likelihood of "permits

(See Permit Transfers on Page 9)

Battle of the Books —

These "reading warriors" came, saw and conquered in last week's "Battle of the Books." For related story and photos, see Back Page.

Got a Cold?

What You Should and Shouldn't Be Doing...

(*Editors Note:* Jacci Tindall is the new Nurse Supervisor at Kanakanak Hospital. She is formerly from Barrow, Alaska where she was the Nurse Manager for Emergency and Outpatient Services at Barrow PHS Hospital. Jacci wrote health articles for the *Barrow Sun* during her stay in Barrow, and we look forward to the articles she plans to write on health issues and new programs in our region.)

by Jacci Tindall, R.N.

Nurse Supervisor, Kanakanak Hospital

A cold is an infection of the nose and throat that is caused by a virus. Antibiotics will not kill the virus. The only treatment for a cold is to allow the body's own natural defenses to activate. By giving the body plenty of rest, a balanced diet and *lots* of water or juice, the body will best be able to fight the cold.

You may have a runny and stuffy nose, headache, fever, cough, sore throat and feel generally miserable. If you have a sore throat, a throat culture can be taken. Your nurse or health aide will notify you if it is positive for strep. Strep throat is caused by a bacteria (not a virus) and antibiotics *are necessary* for treatment. If strep throat goes untreated, damage to the heart can result. If you are given pills for strep throat, be sure to take *every* pill in your prescription. Following are some ways to help your body fight the cold virus:

1. Plenty of rest.

Jacci Tindall, Nurse Supervisor at Kanakanak Hospital, begins a new health feature with this week's edition of the News...

7. Avoid sweets.

8. Throat lozenges or cough drops between gargling will help smooth a scratchy throat and relieve coughs. Do not use more than one lozenge per hour. Overuse of medicated lozenges can kill off the normal bacteria in the mouth and throat and allow an overgrowth of yeast (another problem you don't need).

9. If baby has a runny nose, you can keep it clear by using a bulb syringe. And remember, *NO SMOKING* around baby or children with colds!

10. Decongestants and cough syrups can be obtained at the pharmacy or through your Health Aide. Use only as directed.

11. Aspirin or Tylenol for fever, aches, and pains. Adults can take 2 tablets every four hours with a full glass of water. *DO NOT GIVE ASPIRIN* to children who have flu-like symptoms (nausea, vomiting), or who have chicken pox. Also, adults with ulcers or bleeding problems should not take aspirin

Roof Damage

(Continued from Page 1)

year by heavy snowfall, and this year gave way at a structurally weak point.

Several activities at the school have been cancelled and it is expected that others will not be scheduled due to damage incurred in the shower area.

Price expressed concern that the damage to the roof could present "a major disruption for a big portion of (the high school) program," but added that "I would rather err on the safety side" and "There (must) be no risk" for students for any reason.

Beaver Round-Up activities are not expected to be affected since those programs can be relocated from the affected areas.

School News

(Continued from Page 2)

be able to make everybody happy; and that there may be no easy solutions.

Some groups are preparing further material to take to the School Board or City Council.

In one of Keith Ilurke's Wood Shop classes, some students are learning firsthand about mass production. Albert Roehl, Verla Gregory, Sandra Noden and Kevin Nunn had to come up with an idea and decide whether it was marketable. They chose cutting boards as a first project. A prototype or model was then made. In the production stage, each student was assigned a specific job then all participated in the gluing, sanding and finishing. The students hope to have some finished products ready to sell during Beaver RoundUp. Proceeds will go to cover expenses, with the remainder to be divided among the four students.

The Spanish classes have made dream houses with rooms labeled in Spanish or valentines written in Spanish that are now on display on the hallway bulletin boards.

The annual local Spanish Declamation contest will be held Friday, Feb. 9 with three local judges - Margarita Solano, Amelia Olavarrio and Anne Swan. Each student must recite a memorized Spanish poem. Two winners will then compete in the statewide contest held in Anchorage on March 24.

The Advanced English class, a new offering this semester taught by June Cherry, has been doing a lot of writing. Some students entered a poetry contest and others wrote a peace essay on how the U.S. has been a party to conflict.

Letters of complaint to the FCC (Federal Communications Commission) were also sent objecting to the content of the American Music Awards. Students felt that the dress of the performers, foul language, drugged appearance and booing were not appropriate for a teenage audience. Other letters to the FCC and ABC network objected to some specific children's programs which students felt taught kids to be rude or depicted kids as authority figures rather than adults.

The Freshman and Senior English classes will be doing a student survey this month on teenage romance and marriage. Seniors will be studying literature of the romantic period and the freshmen will begin reading "Romeo and Juliet."

THE JICARILLA APACHE TRIBE
EXECUTIVE OFFICES
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(505) 759-3242

Jicarilla Apache Reservation
February 11, 1887-1987

TESTIMONY OF PRESIDENT LEVI PESATA
ON THE NEED FOR A COMPREHENSIVE
REGIONAL FACILITY

Mr. Chairman and Distinguished members of this Committee, my name is Levi Pesata. I am the President of the Jicarilla Apache Tribe. Our tribe was organized under the Indian Reorganization Act and is governed by its own Constitution. Our membership is currently at 2,840 people. We live in northwest New Mexico approximately 90 miles away from and two thousand feet higher than the nearest city. Many roads leading to the Reservation are in a state of disrepair. We have communications problems with the outside. On occasion there are failures in the delivery of our utilities. Goods and services are kept from us by virtue of the great distance between our seat of government and the cities.

In spite of the natural adversities which we have faced and do face currently, the Jicarilla Apache Tribe is by nature assertive and generally benefits from our innovative outlook. We have made great advances in the development of our natural resources. By taking our assertive nature to the courts we have been victorious on a number of occasions to protect both our sovereignty and our resources. We are currently undergoing a reorganization which we hope will contribute to our efficient delivery of services to our tribal members. In the management of our natural resources we have come to a point where we realize that we must have a comprehensive plan. This plan should also include the surrounding non-Indian communities. By virtue of our isolation Indian and non-Indian community alike find themselves in the same vulnerable position with regards to the lack of economic resources, the lack of governmental services and the lack health services.

And although I begin this testimony by applauding our advances, I must report our great weakness. Our enrolled population is growing at a rate of 3% per year. We expect to double our need for housing, employment and health within the next twenty-four years. Jicarilla Apache patients accounted for 28% of the alcohol related admissions to the Santa Fe Indian Hospital in 1986, yet the Jicarilla Apache Tribe has only 14% of the total service unit population. That hospital is over 130 miles away:

our Tribe is the farthest tribe from the Santa Fe Indian Hospital. From January 1988 to May 1989, it is estimated that 10% of Dulce adolescents between 15 and 19 years of age made suicide attempts. For the 1988-89 school year 13 of 61 female students attending Dulce High School were pregnant. None of these statistics has meaning for planning purposes under the current Indian Health Service guidelines.

It is obvious from the statistics that are mentioned above and from other statistics that IHS has available that the Jicarilla Apache Tribe also has need of medical detoxification, after hours medical services, acute inpatient care, intermediate care, extended care, dialysis services, and inpatient mental health services, acute.

But no one can expect that these services will be provided unless an innovative approach be taken towards the construction of facilities. If we had to wait to be funded through the IHS facilities priority list, it would take 10 to 15 years at best. Yet our facilities are at a crisis. The present IHS clinic consists of a five thousand square foot frame building and five old single wide trailers. The trailers fail fire codes, life safety codes, and handicap access standards, yet patients are seen in them daily. IHS calculates that twenty-five thousand square feet are needed for an ambulatory facility. The seventeen permanent positions are but one third the IHS projected requirements for Dulce. The present facility and staffing levels are so restrictive that many Jicarilla tribal members travel as far as Farmington, 90 miles away, to obtain their health care. The resultant underutilization of the existing facility sabotages our attempts to justify a new facility (using IHS standards).

Historically IHS has had difficulty finding qualified physicians to man the Dulce Health Center. Since Dulce is 90 miles from the nearest hospital physicians must be competent and comfortable in handling emergencies. The condition of this clinic serves as a disincentive. Our isolation is a disincentive. Our lack of housing is a disincentive. And when we offered to supplement the salaries of the doctors in order to get the best qualified, we were told that our contribution would be accepted and donated into a general fund which would benefit all Indian tribes but only incidentally our own.

The Jicarilla Apache Tribe proposes a demonstration project to explore the concept of constructing intermediate care facilities which provide all of the services identified above. Normally, the services we would like to provide would be located in several facilities. For instance, in a clinic, as a separate detoxification unit, as a dialysis unit attached to a hospital, as an acute inpatient care ward in a hospital, etc. Rather than constructing several facilities and providing for the utilities and maintenance cost of all of those facilities, and hiring a separate administrative staff, cooking staff, cleaning staff, and support staff, we propose to combine all into one facility and to combine those resources for the provision of the variety of services we have mentioned.

We have gone through considerable deliberation as to whether or not such facility should be shared with the local non-Indian communities and that deliberation has resulted in a resounding affirmative vote. We have seen the failure of local health organizations off the reservation. Although adjacent communities may not suffer from the same behavioral health problems as we do, we see that we have an equal and joint concern in the economic and social well-being of the region. We therefore have concluded that non-Indians should be served at our new facility.

The Tribe is prepared to pay one-half of the cost of such a facility. There are two possible ways this could be accomplished. One option is for the Tribe and IHS each to provide half of the construction funds. If this is not feasible, the Tribe will pay the full up-front costs of construction under an agreement whereby IHS would compensate the Tribe for half of the construction costs through lease or rental payments over a 10 or 20 year period. The Tribe has dedicated a parcel of land for this project which is centrally located and which is large enough to accommodate future needs for expansion.

Either of these approaches will reduce the burden on the Federal Treasury by one half. The second option would have the added benefit of stretching out the Federal government's costs over a long period of time and thereby reducing the immediate pressure on the federal budget over the next few years during which projections indicate a continuing tight budget situation. Despite their benefit to all parties -- the Tribe, the Federal government and the local non-Indian community, neither of these options is permissible under existing law. We therefore urge the Congress to enact a demonstration program that would enable tribes such as Jicarilla to test these innovative methods for providing critically needed health facilities to Indian communities.

Once the facility is operational the Tribe will take necessary steps to assume management responsibilities under Public Law 93-638. A reasonable fee-for-service scale will be developed for the non-Indians using these facilities, with all funds returning to the clinic operations or for amortization of the construction costs. We feel confident that this facility will serve as a model of health care in rural communities. Beyond health care, however, participation in this proposal will serve as a model of government-to-government relations. The project will bind not only the community but the surrounding region and serve, possibly, to stimulate our societies, and our economies.

We appreciate this opportunity to testify. We also express our deep appreciation to the Committee for its continuing effort to find new and creative solutions to the problems facing Indian tribes and Indian people.

Respectfully Submitted,

Levi Pesata,
President

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